



3 1761 11850066 9



Ontario

82

Stated Case  
ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND  
RELATED MATTERS.

Hearing held  
8th floor  
180 Dundas Street West  
Toronto, Ontario

Dr. Rowley

The Honourable Mr. Justice S.G.M. Grange

Commissioner

P.S.A. Lamek, Q.C.

In the Counsel

E.A. Cronk

Associate Counsel

Thomas Millar

Administrator

LEAC

Transcript of evidence  
for

December 15, 1983

VOLUME 82

OFFICIAL COURT REPORTERS

Angus, Stonehouse & Co. Ltd.,  
14 Carlton Street, 7th Floor,  
Toronto, Ontario M5B 1J2

595-1065



Digitized by the Internet Archive  
in 2023 with funding from  
University of Toronto

<https://archive.org/details/31761118500669>





ROYAL COMMISSION OF INQUIRY INTO CERTAIN  
DEATHS AT THE HOSPITAL FOR SICK CHILDREN  
AND RELATED MATTERS.

Hearing held on the 8th Floor,  
180 Dundas Street West, Toronto,  
Ontario, on Thursday, the 15th  
day of December, 1983.

- - - - -

THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner  
THOMAS MILLAR - Administrator  
MURRAY R. ELLIOT - Registrar

- - - - -

APPEARANCES:

P.S.A. LAMEK, Q.C.)	Commission Counsel
E. CRONK )	
D. HUNT )	Counsel for the Attorney
L. CECCHETTO)	General and Solicitor General
	of Ontario (Crown Attorneys
	and Coroner's Office)
I.G. SCOTT, Q.C.)	Counsel for The Hospital for
M. THOMSON )	Sick Children
R. BATTY )	
B. PERCIVAL, Q.C.)	Counsel for The Metropolitan
D. YOUNG )	Toronto Police
W.N. ORTVED	Counsel for numerous Doctors
	at The Hospital for Sick
	Children
F. KITELY	Counsel for the Registered
	Nurses' Association of Ontario
	and 35 Registered Nurses at
	The Hospital for Sick Children







APPEARANCES:

D. BROWN	Counsel for Susan Nelles - Nurse
E. FORSTER	Counsel for Phyllis Trayner - Nurse
J.A. OLAH	Counsel for Janet Brownless - R.N.A.
B. KNAZAN ) B. JACKMAN)	Counsel for Mrs. M. Christie - R.N.A.
S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
F.J. SHANAHAN	Counsel for Mr. & Mrs. Dominic Lombardo (parents of deceased child Stephanie Lombardo); and Heather Dawson (mother of deceased child Amber Dawson)
W.W. TOBIAS	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai)





INDEX OF EXHIBITS (Cont'd)

<u>No.</u>	<u>Description</u>	<u>Page No.</u>
294	Memorandum from J. Douglas Snedden; dated April 13th, 1981; with attachments.	7945
295	Photograph of original photograph marked as Exhibit 29B at the preliminary hearing concerning Susan Nelles; photograph of the contents of the list of resuscitation tray and crash cart on Ward 4A at The Hospital for Sick Children.	7951
296	Abstract from the Ward 4A/4B Policy Book.	7958







INDEX OF WITNESSES

<u>NAME</u>	<u>Page No.</u>
<u>BROWNE</u> , Carol; Sworn	7763
Direct Examination by Ms. Cronk	7763

INDEX OF EXHIBITS

<u>No.</u>	<u>Description</u>	<u>Page No.</u>
290	Curriculum Vitae of Carol Browne.	7767
291	Extracts from "Policy and Information Manual - Department of Nursing - The Hospital for Sick Children", 1977-June 1981.	7791
292	Standards of Nursing Practice for Registered Nurses and Registered Nursing Assistants, College of Nurses of Ontario, June 1976-1983.	7884
293	Extract from Ward 4A/4B Policy Book entitled "Transcribing of Doctors' Orders - Guidelines".	7931







1

2

/DM/ak

---Upon commencing at 10:00 a.m.

3

4

THE COMMISSIONER: Have you any thoughts as to how we should proceed on this matter? Miss Forster or Mr. Brown, who is going to go first?

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

I should tell you before we start that there are in effect three motions. There is one joint motion the stated case on the naming names problem, and there is one on Notice. There is also Mr. Olah's motion. I am prepared to hear them any way you like. I think I should tell you beforehand my present intention is to accede to the request on the naming of names and to reject the request on the Notice question, and that may shorten the argument somewhat. In the naming of names I don't intend to state the case precisely the way you have it because I don't think that is quite what I intended and I don't like the use of the words deliberate and negligent because they may have a legal connotation, I have a manner in which I would like to state it. However, bearing that in mind, are you first?

20

21

MR. BROWN: Bearing that in mind I will make the first submission, yes.

22

23

24

25

THE COMMISSIONER: Yes, all right.

MR. BROWN: In view of what you have said, Mr. Commissioner, about the first question, I





1  
2 don't intend to ---

3 THE COMMISSIONER: I will tell you  
4 the manner in which I intend, I certainly will hear  
5 anyone in opposition on the question, but the manner  
6 in which I intend to do it: was I right in determin-  
7 ing that the terms of reference of this Commission  
8 entitle me subject to certain qualifications I have  
9 set forth to express my opinion upon whether the  
10 death of any child was the result of the action of  
11 any person or persons. All right. Have you any  
12 comments with respect to that?

13 MR. BROWN: That the terms, whether  
14 you were right ---

15 THE COMMISSIONER: Was I right in  
16 determining that the terms of reference of this  
17 Commission entitle me subject to certain qualifications  
18 I have set forth, and those are the qualifications  
19 found in the Reasons for Judgment, to express my  
20 opinion upon whether the death of any child was the  
21 result of the action of any person or persons.

22 MR. BROWN: Yes, I think that is  
23 fine.

24 MS. FORSTER: I am sorry,  
25 Mr. Commissioner, just before Mr. Brown begins. Is  
there not a distinction between your finding that the







1  
2 death was the result of some act on the part of a  
3 person and actually naming that person.

4 THE COMMISSIONER: Well, you know,  
5 but I intend, in case you are worried about that,  
6 I certainly intend that to mean that I can name a  
7 person or persons. I also want to be able to  
8 consider whether it was or whether it was not and  
9 I am certainly going to consider whether it was  
10 accidental or it wasn't, but in my view if I say  
that, that is what I mean.

11 MS. FORSTER: Okay.

12 THE COMMISSIONER: All right.

13 MR. BROWN: I suppose the only  
14 concern I have, Mr. Commissioner, would be the  
15 language of question one, is that the language be  
16 such as to allow the fullest argument on the ability  
17 of a provincial public inquiry to perform that  
18 particular act. I think the argument, at least  
19 from our point of view has two aspects; the first  
20 is (a) construction of the terms of reference them-  
21 selves; but secondly the constitutional setting under  
which the terms of reference must be construed.

22 THE COMMISSIONER: Oh no, you can  
23 do that.

24 MR. BROWN: Yes. I think the  
25







1  
2 language of that question allows us to do that and  
3 that is the only concern I would have would be the  
4 language of question one. I think the way that it  
5 is phrased ---

6 THE COMMISSIONER: Well, personally I don't  
7 intend to exclude the constitutional question and  
8 you can argue that to your heart's content before  
9 the Divisional Court.

10 MR. BROWN: Yes.

11 THE COMMISSIONER: All right.

12 MR. BROWN: With respect to the  
13 second question then, Mr. Commissioner, my reading  
14 of the ruling which you gave in this matter was that  
15 in essence the application that was made was premature  
16 and that the matter really did not have to be  
17 addressed at this point since no decision on that  
18 could be made until the evidence had been heard in  
19 its entirety, and that perhaps at that point in time  
20 there would be some question as to whether or not  
21 Section 5-2 would have to be invoked and what rights flow  
22 from under that. I can understand your concern that  
23 we have perhaps requested the case to be stated on  
24 a matter that is premature.

25 The matter that gives me some diffi-  
culty, Mr. Commissioner, is that at some point of





1  
2 time that particular provision may well have to be  
3 construed. I think from your ruling you have indi-  
4 cated the point of time where it would apply would  
5 be after all of the evidence is in. I think in the  
6 submissions that were made to you ---

7 THE COMMISSIONER: I am not at all  
8 sure that it ever has to be construed, quite frankly  
9 I don't find any difficulty in interpreting that  
10 section, none whatever, it is one of the easiest  
11 sections I have ever seen. It says you have to have reason-  
12 able notice of what is alleged against you and you  
13 have to have an opportunity to be heard. That is  
14 what Courts are doing all the time, and I have been  
15 brought up in that tradition and that is what I am  
16 trying to do. Now, I don't find the slightest bit  
17 of trouble with it and it is entirely hypothetical,  
18 academic, and the Divisional Court would laugh you,  
19 at least I think, would laugh you out of Court if you  
20 applied for it, because they say it is not necessary,  
21 therefore, why have it now. Now, if I didn't know  
22 what to do I might be concerned about it. Would  
23 somebody please tell me where I am wrong, am I  
24 wrong? Isn't that what it says, that you have to  
25 have reasonable notice and that you have a right to  
be heard, isn't that what it says? Is there







1  
2 something else it says that I have missed in all  
3 these years?

4 MR. BROWN: Sir, I don't want to  
5 argue the merits of the matter with you.

6 THE COMMISSIONER: No.

7 MR. BROWN: All I would simply submit  
8 is that it is true one does have to have reasonable  
9 notice. In view of the lack of jurisprudence on that  
10 particular section there may be some question as to  
the form in which the Notice must be given.

11 THE COMMISSIONER: Is a stated case  
12 supposed to be for this sort of academic question? Isn't  
13 it supposed to be something that arises in the course  
14 of the hearing, or the course of the inquiry, some-  
15 thing that the Commissioner can't deal with or perhaps  
16 something that he is doing wrong. What am I doing  
17 wrong I ask you at the moment, what am I doing wrong?  
18 If you will tell me what it is I will be happy to  
deal with it.

19 MR. BROWN: Well, I understand the  
20 difficulty, Mr. Commissioner, in that perhaps the  
21 motion is premature. I suppose the only issue  
22 and I would want to make is this; first the Statute  
23 is very explicit in that it appears to be confer  
24 some sort of statutory right upon persons who may be  
25





1  
2 affected by findings as they are disclosed in the  
3 report. To the extent that there is a statutory  
4 right conferred, and some question may arise as to its  
5 infringement, I think the subject matter is one that ---

6 THE COMMISSIONER: Has it been  
7 infringed to date?

8 MR. BROWN: Well, I think ---

9 THE COMMISSIONER: Tell me what I  
10 have done wrong? I know Mr. Olah will tell me what  
11 I have done wrong but I don't agree with him, but  
12 you tell me what I have done wrong?

13 MR. BROWN: Well, I confess,  
14 Mr. Commissioner, the motion itself may have been  
15 premature, and that to date there may not have  
16 been any error in the application of that section,  
17 but I think there is some confusion, at least to my  
18 mind, and perhaps in the mind of some of the other  
19 counsel for the applicants, as to when that section  
20 comes into play and if indeed it comes into play  
21 what are the obligations under that section and  
22 what are the rights under that section.

23 THE COMMISSIONER: As I don't know  
24 what I am going to do I really can't determine whether  
25 nobody can say now that I have done it or will do it  
wrong, or won't do it wrong, I don't know what I am







1  
2 going to do with respect to Notice. I have been  
3 trying to tell Mr. Olah and other people that that  
4 is precisely the position I am in. You apparently  
5 would like to have me ask the Divisional Court to  
6 solve a whole lot of problems of law which I am  
7 quite capable of at least applying my mind to, but  
8 I don't know what they are because I don't know  
9 whether I am going to want to give you or your client  
10 notice, I don't know that I want to give Mr. Olah or  
11 his client notice, or what kind of Notice, or what  
12 I am going to do because the evidence is not in,  
13 that is my whole point. If you can persuade me I  
14 am wrong, that there is something that the Divisional  
15 Court should be telling me I should be doing now  
16 I will be happy to consider it, but I don't know  
17 what it is. I keep asking, I keep asking people  
18 what have I done wrong, what am I planning to do  
19 wrong. I will concede that as far as the naming of  
20 names is concerned that is a good healthy question  
21 and I tell you now that I intend to weigh the  
22 evidence and to make a determination, if I am wrong  
23 in that I want to be told by the Divisional Court  
24 that I am wrong, that is important. I don't know  
25 what kind of notice I am going to give, I don't know  
whether I am going to give any kind of notice.





1  
2  
3 Certainly as far as I have been able to I have been  
4 giving you and anyone else who might conceivably  
5 be affected a right to be heard and a right to  
6 appear at this hearing. So I repeat my question,  
7 what have I done, what do I propose to do that is  
8 wrong?

9  
10 MR. BROWN: Well, the only matter  
11 that I would submit to you is one of timing.

12 THE COMMISSIONER: Yes.

13 MR. BROWN: That from your present  
14 ruling I take it that the decision as to whether or  
15 not Section 5-2 applies will be made after all of  
16 the evidence is heard.

17 THE COMMISSIONER: Section 5-2  
18 certainly applies, there is no question it applies,  
19 it applies, that it's the law of the land. Whether  
20 it will require me to give any more notice than I  
21 have already given; whether it will require me to  
22 give anybody any further opportunity to be heard  
23 or not I can't say because I don't know.

24 MR. BROWN: I believe in the  
25 submissions that were made before you when this was  
argued orally, if I recall Mr. Strathy may have made  
some suggestion that the appropriate time for the  
application, or for consideration of whether or not







1  
2 Notice had to be given, was not after all the evidence  
3 was in, but after the close of Commission Counsel's  
4 case.

5 THE COMMISSIONER: That may well be,  
6 that may well be but we haven't closed our case yet.

7 MR. BROWN: Well, in that sense  
8 perhaps the motion is premature and we should wait  
9 until that point. The main concern I have in respect  
10 to the second question is the timing, and when you  
11 do have to consider whether or not to give notice and  
12 perhaps I would submit a narrow question to be  
submitted would be ---

13 THE COMMISSIONER: Supposing we do  
14 give, supposing I do decide I have to give some  
15 notice at the end of the Commission's case; and  
16 supposing in the course of the further evidence that  
17 is produced by other people further evidence comes  
18 out against you or against somebody else, what do I  
do then, do I give some further notice?

19 You see, what is it going to mean,  
20 if I bring an application now the Divisional Court  
21 gives me their best answer, the circumstances  
22 change and we have to go back to the Divisional  
23 Court again and again and again and they are not  
24 going to be pleased about that, they are just not  
25





1  
2 going to be. They seem to think they are overworked  
3 now, I can't imagine why, but they do. It was a  
4 pretty easy job when I had it, I thought.

5 MR. BROWN: Well, it may well be  
6 that you would have to give further notice to  
7 additional people after having already given Notice  
8 once, after Commission Counsel's case is in. I  
9 submit at least one would know that the initial  
10 consideration would have to be made after Commission  
11 Counsel's case has gone in. At that point the  
12 parties perhaps most directly affected would be  
13 put on notice if such be the case and one could then  
14 proceed. At least one knows the minimum point of  
15 time, or the earliest point of time at which it has  
16 to be considered. I would submit that if evidence  
17 comes out which perhaps points or implicates other  
18 people, after the initial Notice has been given, all  
19 well and fine, I don't think that would necessarily  
20 require however another trip up to Divisional Court  
21 because at least one knows at that point in time  
22 when notice has to be given.  
23  
24  
25

-----







E/BN/ko

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

So in my submission, Mr. Commissioner, the prospect of additional trips up to Division Court may not be a real prospect as long as one can determine the earliest point of time when one must consider whether or not the Notice must be given.

That is really all I have to say on the substance of it. I can understand your concern about the hypothetical and the broad language in which the question was posed to you, and I would therefore submit that perhaps a narrower question could be framed limited simply to the timing and the timing being between the close of the Commission's case or the adducement of all evidence with respect to Phase 1, and that that be the subject matter of the second question.

As a matter of convenience, Mr. Commissioner, I would submit that if the first question is going to be argued before the Divisional Court, the first and the second questions are linked to some degree inasmuch as if the Divisional Court upholds your ruling that you do have power and authority under the Terms of Reference to name names, then the question as to whether or not Notice must be given and when it must be given under Section 5(2) then becomes of even greater importance, and I would submit





B 2

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

that there is an element of convenience perhaps in having the two matters addressed at the same time.

Those are really, Mr. Commissioner, all the submissions I have on the second question.

THE COMMISSIONER: Thank you. Now, is there anyone else in favour of the second question, in favour of my stating on the second question? Mr. Olah, I will deal with yours later.

MR. OLAH: Thank you, sir.

THE COMMISSIONER: The second question as posed by the Applicants, is there anyone else who wants to say anything else in favour of it?

MS. FORSTER: Yes, I would, sir.

THE COMMISSIONER: Yes, all right.

MS. FORSTER: Sir, I agree with the submissions made to you by Mr. Brown. I think our major concern was expressed by you this morning when you said that you did not know what kind of Notice you would give or whether you would give Notice. The problem that gives us is if you should decide, sir, that you are going to make findings of misconduct and your decision to name names is upheld by the Divisional Court, we do not know what we can expect from you.

Obviously, if there is some evidence







B 3

1  
2 that shows that our client was guilty of grave mis-  
3 conduct, we have Notice in the sense that we know what  
4 that evidence is, but there are finer lines to be  
5 drawn, and if you, in your own mind, decide that there  
6 is evidence, or you can interpret the evidence such as  
7 to make the finding of misconduct, unless we know that  
8 we can expect some kind of Notice from you that your  
9 mind is committed in that way, we do not know how to  
meet it and we would like the opportunity --

10 THE COMMISSIONER: Well, you will not  
11 know anything about how my mind is committed until you  
12 get the report because I do not consider my mind, such  
13 as it is, as committed to anything until I sign the  
report.

14 MS. FORSTER: Sir, we are not  
15 suggesting that you necessarily have to make a decision  
16 now as to whether you are going to give any particular  
17 party notice.

18 What we want to know, at least what my  
19 client wants to know from you is should you decide that  
20 there is a possibility that you are going to make a  
21 finding of her, we want to know what we want to know  
22 what we can expect from you. Are you going to decide  
23 that because we have standing we have Notice, so  
24 nothing more need be said, or are we going to get some  
25 kind of formal Notice?





B 4

1

2

THE COMMISSIONER: I have told you

3

that until the Courts tell me I cannot, I intend to

4

weigh the evidence of what may or may not have been

5

done by certain persons and to name those persons.

6

Now, that is clear to you, is it not? That is what

7

I intend to do and that is why you are dragging me

8

kicking and screaming before the Divisional Court for

9

them to tell me I am wrong; is that not right? You

10

know what I intend to do?

11

MS. FORSTER: Yes.

12

THE COMMISSIONER: There cannot

13

possibly be any doubt in your mind as to what I intend

14

to do. The only problem is going to be whether you

15

will have at the appropriate time sufficient Notice of

16

what might conceivably happen to you and have been

17

given sufficient opportunity to be here.

18

As I do not know what the extent of

19

the evidence may be, I cannot conceivably give you any

20

Notice yet, can I?

21

MS. FORSTER: No, and I think you have

22

expressed our concern precisely. The problem is we do

23

not know --

24

THE COMMISSIONER: Yes, ad nauseam.

25

MS. FORSTER: We do not know whether

we are ever going to get anything more from you or, if





B 5

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

so, what form it should take.

THE COMMISSIONER: I do not either,  
I promise you. I am not keeping anything from you.  
I do not know either. But I do know you will be the  
first to hear.

MS. FORSTER: Sir, in our submission  
I think we are entitled to know that we can, if you  
decide, we can expect something from you in terms of  
you are going to name our name and make the appropriate  
submissions, and at this stage I do not think your  
ruling goes that far. As Mr. Brown said, I think  
given that it is likely we are going to Divisional  
Court anyway on the question of naming names, and the  
question of Notice is really tied very closely to that,  
it is appropriate to have both issues dealt with  
together.

THE COMMISSIONER: Yes, all right.  
Anyone else supporting the second question in the  
joint application in the stated case?

MS. KITELY: I likewise support my  
friends, Mr. Brown and Ms. Forster, and adopt their  
submission.

I have one further comment, and that  
is that insofar as we act both for the Association  
and for 39 individuals, it is important that we know







B 6

1

2

at the absolute earliest opportunity. My friends all  
have only one client and we have a lot more than that.

3

4

THE COMMISSIONER: Well, I really  
have not got anything against any of your clients so  
far.

5

6

MS. KITELY: So far. So far as we  
know.

7

8

THE COMMISSIONER: Well, if something  
comes up, I will certainly let you know, and I hope  
you will be here to hear it, that is all. But if you  
are not here, I will tell you all about it.

9

10

11

12

MS. KITELY: Thank you, sir. I will  
not add any more to my friends' submissions except  
that.

13

14

THE COMMISSIONER: Yes, Ms. Jackman?

15

16

MS. JACKMAN: Mr. Commissioner, if  
you recall, we took a somewhat different position on  
Notice when my partner argued before you. However,  
we have signed the request for stated case on that  
second point as well. We support Mr. Brown's  
submissions as well because we feel that the decision  
on Notice would affect our client as well as the  
others and, therefore, we would like to see it  
as well.

17

18

19

20

21

22

23

THE COMMISSIONER: Yes, all right.

24

25





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Thank you. Anyone else supporting this application?

Now, in an ordinary case I would say to anyone else that I do not need to hear you on that second one, but if any of you feel that you want to make any statement with respect to it, I am dealing only with the second application on the joint -- the second question on the joint application. Does anyone else want to say anything?

MS. CECCHETTO: The only point I would make, Mr. Commissioner, with respect to the second point is that the Public Enquiries Act very clearly states that it is for you to determine the procedure to be followed, and I do not see how my friends can at one and the same time concede that the Notice point is premature and ask you to state a case because stating a case to the Divisional Court, what you are asking the Divisional Court to do is to supervise the exercise of your jurisdiction. If you have not proceeded into that step of the case yet, I do not see how you can state a case on that point. They simply cannot indicate to you how you should proceed in this matter at this time. It is only when you exceed your jurisdiction that then the basis is laid to state a case to Divisional Court.

THE COMMISSIONER: Yes, all right.







1  
2 Thank you. Anyone else?

3 I think I will deal with Mr. Olah's  
4 motion now, and then I will come back to those  
5 opposed, if any, to the stating of a case on the  
6 naming of names.

7 MR. OLAH: Mr. Commissioner, in  
8 argument you posed a question to my friend, Mr. Brown,  
9 and that really is the nub of the problem. You said,  
10 "What have I done wrong?".

11 The problem we have got is this, this  
12 is the concern: When you responded to Mr. Sopinka on  
13 October 18th you very directly indicated that any and  
14 all members of the Trayner team may be found to be  
15 implicated, and you suggested that it was due to  
16 funding. Now, we took that to mean that from the very  
17 inception of these proceedings that we should have  
18 been aware of the fact that there may be a finding of  
19 misconduct against and all members of the Trayner team,  
20 and we took that to mean that we had been under Notice.  
21 That really is the issue, whether in fact you have  
22 given us Notice under Section 5(2) or whether not.

23 If I interpreted your remarks correctly  
24 this morning when you said, sir, I cannot give any  
25 Notice yet, if in fact you were saying, sir, that you  
have not given any Notice to our client, Janet Brownless,  
then I do not want a stated case.





C/BM/ak

1  
2 All I want to know, sir, simply is  
3 whether you feel you have given us Notice or not.  
4 Obviously if you haven't given us Notice then there  
5 is no basis for stating a case, but if you feel that  
6 you have given us Notice then it is just --

7 THE COMMISSIONER: Please let me  
8 tell you that there is no requirement to give Notice.  
9 What it says:

10 "No finding of misconduct on the part  
11 of any persons shall be made against  
12 him in any report of the Commission  
13 after an inquiry unless the person  
14 had reasonable Notice."

15 It is not a question of whether I  
16 have given you Notice, it is a question of whether  
17 you have had reasonable Notice. Therefore, I have  
18 to then consider when the evidence is in whether you  
19 have had reasonable Notice.

20 Supposing something should come up,  
21 for instance - this is just an example - that, let us,  
22 say, and there is absolutely not a scrap of evidence  
23 to support this, but that your client had retained  
24 someone for the purpose of doing something to some  
25 of these babies. Now, that clearly is something of  
which you had no Notice at all, none whatever, and





1  
2  
3 I clearly would feel obliged to give you some Notice  
4 of that if you didn't have it, if you didn't have  
5 it already.

6 I don't know what the evidence is  
7 going to disclose. I have told you that to date we  
8 do not appear to have any evidence against your  
9 client that would justify a finding of misconduct  
10 against her in the report. I have said that I believe,  
11 have I not?

12 MR. OLAH: Yes, you have, sir,  
13 fairly.

14 THE COMMISSIONER: And Commission  
15 Counsel has said that. That tells you that at the  
16 moment you don't have to worry about anything but  
17 I tell you further that we are going to receive  
18 evidence, we have received some evidence and you  
19 yourself have asked a great many questions in the  
20 course of cross-examination, which seems to be to the  
21 effect that your client could not have been responsi-  
22 ble for any conscious overdose or even an unconscious  
23 overdose of digoxin. That's the sort of evidence that  
24 we have had. You clearly know what the problem is.  
25 What the problem so far as I know you clearly know  
and it is obvious from the course of your cross-  
examination.







1  
2  
3 MR. OLAH: Sir, I understand from  
4 your point of view but may I ask you to step into  
5 my shoes and look at the section and the statute  
6 the way I believe it is intended to be interpreted  
7 and that says that if you have any intention to  
8 report upon my client --

9 THE COMMISSIONER: You're asking  
10 me to tell you to go home.

11 MR. OLAH: No.

12 THE COMMISSIONER: And then if  
13 something happens to say come on back, Mr. Olah, we  
14 will repeat all the evidence that we have had.

15 MR. OLAH: No, absolutely not,  
16 absolutely not.

17 THE COMMISSIONER: Is that what you  
18 want me to do?

19 MR. OLAH: The only simple question  
20 I am asking up to this stage is whether you feel  
21 you have given me Notice.

22 THE COMMISSIONER: Well, I don't know.  
23 I have said that before, I don't know, and it is not  
24 a question of whether I have given you Notice, I  
25 can tell you that such Notice as I have given you is  
on the record; such Notice as I have given. Whether  
that Notice is adequate or not, I don't know, and





1  
2  
3 whether the other Notice that you have had, the  
4 Notice that you have had is all of the evidence that  
5 has come to you, that, and if none of it is, as you  
6 know, another person in the same position as you has  
7 decided not to turn up, you don't have to turn up  
8 if you don't want to, you can go away, you're not  
being compelled to be here.

9 MR. OLAH: But may I point out that  
10 I understand the commonsense and the logic of it  
11 from your position but from my position I say, with  
12 the greatest of respect, that at any and all points  
13 in time before you, sir, I am entitled to know whether  
14 you feel you have given me Notice or not because,  
you see, I have to govern myself accordingly.

15 THE COMMISSIONER: Yes, all right.

16 MR. OLAH: And that really is the  
17 difference between us, sir. I say that I can only  
18 be one or both; I can be either a 5(2) party, which  
19 inherently means I am also a 5(1) party or I am  
20 simply a 5(1) party. I cannot be in a state of  
21 flux, as you seem to feel, that I may have had Notice  
22 or I may not have and that you will determine retro-  
actively whether I have had Notice.

23 What I am saying is that in law I  
24 am either one or the other.  
25





5

1  
2  
3 THE COMMISSIONER: What difference  
4 does it make. Now, if I were to comply with your  
5 request and if I were to say you haven't had Notice,  
6 which incidentally I don't feel I can do because I  
7 don't know what it is that is going to be alleged  
8 against you and I don't know - I have said to you  
9 several times, and I am tired of saying it and I'm  
10 going to say it for the last time at the moment I  
11 do not have anything upon which I could make a  
12 finding of misconduct against your client. That is  
13 as far as I am going to know. But you know what  
14 I'm worried about. I hope it is the same thing that  
15 you are worried about, namely, that your client's  
16 name may come up in circumstances that might justify  
17 a finding of misconduct. That is why you're here.

16 MR. OLAH: I understand that, sir.  
17 All I am saying is that your interpretation of the  
18 section and mine are somewhat different. I say that  
19 if that point ever arises then you are obliged to  
20 give me Notice and until that point I still maintain  
21 my status as a 5(1) party; you on the other hand, sir,  
22 seem to interpret it that I may be both, even though  
23 I have had no notice of any kind.

23 You will recall what your own counsel  
24 said when we argued this that if there has been any  
25







1  
2 Notice given to anyone in this case the delivery of  
3 the full Atlanta Report may constitute such Notice  
4 and I haven't had delivery.

5 THE COMMISSIONER: I think where  
6 the real problem is, I was once in your position,  
7 so, I can understand your position. As far as I  
8 know you have never been in my position.

9 MR. OLAH: No, I can guarantee you  
10 that, sir.

11 THE COMMISSIONER: Some day,  
12 some day, and it may be in the far distant future,  
13 there is facing me the task of making a report. I  
14 can't break off in the middle, say, at 4 o'clock in  
15 the morning when I suddenly decide, ah, the villain  
16 is, that at that point it is not possible for me  
17 to get and to stop writing the report and get it.  
18 That isn't my idea of how one does this sort of thing.  
19 Where there is a danger to someone, if it is going  
20 to happen, they are entitled to reasonable Notice of  
21 that. I can't conceive of the fact that you haven't  
22 had reasonable Notice and on top of that you have  
23 been given all of the evidence that we have at the  
24 moment against you. Now, I don't know how I can run  
25 the Commission otherwise.

MR. OLAH: You see, with the greatest





1  
2 of respect, we have a fundamental different interpre-  
3 tation of what the statute compels you to do.

4 THE COMMISSIONER: That is what the  
5 Divisional Court is for.

6 MR. OLAH: Well, that is why I am  
7 asking that you state a case on my issue alone because  
8 my issue is very different than anyone elses. I  
9 respectfully submit that because of the difference,  
10 we have an opinion as to what your obligations are,  
11 I would respectfully urge you to state the stated  
12 case so that we once and for all have a determination  
13 of that very central issue because it is - may I use  
14 an analogy, Mr. Commissioner - it is like being in  
15 a criminal court and counsel for being a witness and  
16 all of a sudden half way through or three-quarters  
17 of the way through the trial the judge says, but  
18 right from the word go you have been in the prisoner's  
19 box and you should have known about it.

18 THE COMMISSIONER: Yes, but the  
19 difference is this is not a trial.

20 MR. OLAH: I understand that, that's  
21 why I say it is an analogy.

22 THE COMMISSIONER: We don't follow  
23 the same rules.

24 MR. OLAH: That is why it is an  
25





1  
2 analogy but a jeopardy in both cases exist to the client.

3 What I am saying, sir, is (a) I am entitled to know  
4 whether I am a person at large or whether notionally  
5 I am an accused person and (b) I am entitled to have  
6 particulars of the allegations of misconduct. That  
7 is why I say, with the greatest of respect, that I  
8 am entitled to know where I stand at this stage and  
9 at any stage of the proceedings. I understand your  
10 dilemma and I say the resolution to your dilemma is  
11 that if you ever reach during the proceedings the  
12 threshold where you are convinced that there is  
13 misconduct and you will report, then you can come back  
14 give Notice and at that point I've got an opportunity  
15 to reply, and I think that is the way out of your  
16 dilemma.

17 THE COMMISSIONER: That may well be,  
18 that may well develop, that may well develop.

19 MR. OLAH: If my interpretation  
20 is correct then I can still be a 5(1) party and all  
21 I am asking is, I would like to know today whether  
22 I am a 5(1) party, in view of your language to  
23 Mr. Sopinka which seems to suggest you have given  
24 me Notice. That really is the key and central issue.

25 THE COMMISSIONER: Yes, all right.

MR. OLAH: Thank you, sir.







1  
2  
3 THE COMMISSIONER: Thank you. Anyone  
4 else in support of Mr. Olah's motion?

5 Once again, I say that I do not need  
6 to hear from anyone in opposition to it. If anyone  
7 wants to say anything they may say it.

8 All right. Well then, I would like to  
9 hear from anyone in opposition to the stating of a  
10 case on the naming of names, bearing in mind it is  
11 my present intention to state a case in the following  
12 form: Was I right in determining that the terms of  
13 reference of this Commission entitle me, subject to  
14 certain qualifications I have set forth, to express  
15 my opinion on whether the deaths of any child was  
16 a result of the action of any person or persons.  
17 Anyone wishing to say anything in opposition to my  
18 stating a case on that question?

19 MR. SCOTT: Well, my only one  
20 reservation is, the question I take it is not in the  
21 form of your decision, it is different.

22 THE COMMISSIONER: No, it is  
23 different, it is different.

24 MR. SCOTT: Certainly safer.

25 THE COMMISSIONER: Well, it better  
sets forth what I really intended. What I intend  
to do is weigh the evidence and if I can reach a





1  
2 conclusion, whether any person was or conceivably  
3 was not the actor in the bringing about the deaths  
4 of the children.

5 MR. SCOTT: I have no interest in  
6 this, I don't oppose you stating any case you want  
7 but I understood your ruling to deal with deliberate-  
8 ness and the question doesn't raise that issue.

9 THE COMMISSIONER: Well, the reason  
10 I have left out deliberate and negligence -- this  
11 surely gives me the right to say whether it is  
12 accidental or not and it is perfectly clear from  
13 my reasons that that is what I intend to do, to  
14 determine whether it was accidental or not. But I  
15 don't like the words deliberate or negligent because  
16 deliberate has now got a special legal meaning  
17 because of the Criminal Code and negligence and a  
18 particular meaning in civil responsibility and I  
19 don't want to use those words.

20 MR. SCOTT: Well, what I am really  
21 trying to do is prevent two trips to the Divisional  
22 Court; one is bad enough.

23 THE COMMISSIONER: Well, if you  
24 can think of a better way of phrasing the question  
25 I would be happy to receive it.

MR. SCOTT: Well, the fear I would





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

have with that form of the question is that when  
somebody gets to the Divisional Court and argues  
that you shouldn't be able to make a finding that without  
using the word "murder" presents a prima facie case  
of murder, the answer will be, unlike your reasons,  
that the question posed doesn't say you are going to  
do that, it simply says whether the action of anybody  
was -- Now, I don't care.

-----







D/DM/ko

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

THE COMMISSIONER: I don't understand, what is wrong with, was the result of the action or actions of any person or persons?

MR. SCOTT: Well if your report is confined to the determination that the digoxin was administered as a result of the action of X and contains nothing more, that would be satisfactory to certain persons, but if you are, for example, --

THE COMMISSIONER: Do you want me to put that the death of the child was the result of the action accidental or otherwise of any person?

MR. SCOTT: Well, I don't care.

THE COMMISSIONER: No, no, but that is what I intend to do and I don't mind putting those words in "accidental or otherwise".

MR. SCOTT: Because I don't think anybody here will object to a determination if it was the result of the action of X. What they are concerned about is that you may find it was the result of the conscious and deliberate action of X.

THE COMMISSIONER: I thought the result of the action of any person or persons obviously means either conscious or unconscious.

MR. SCOTT: As I say --

THE COMMISSIONER: As I say I will put





D 2

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

as a result of the action accidental or otherwise.

MR. SCOTT: It would be a misfortune if we got up there and the question wasn't one that satisfied --

THE COMMISSIONER: Accidental or otherwise by any person or persons, does that solve your problem?

MR. SCOTT: Yes.

THE COMMISSIONER: Now Mr. Labow.

MR. LABOW: Mr. Commissioner, the parents' counsel, counsel for all of the parents don't object to your stating the case on this issue in any way, but we do have a concern that we would like to express to you.

THE COMMISSIONER: Yes, certainly.

MR. LABOW: That the stating of the case could in some way impede the hearing of certain evidence.

THE COMMISSIONER: They haven't asked that, they haven't asked that and I don't intend to allow it to happen.

MR. LABOW: Well Mr. Commissioner, if the stating of this case will not impede the hearing of any and all evidence in this matter the --





D 3

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

THE COMMISSIONER: There is nothing in the case that I have been asked to do that has anything except what will be in my report and we have been receiving that kind of evidence. As I pointed out to Mr. Olah, he has been asking those sort of questions throughout and we have already got some of the evidence with respect to the whereabouts of the nurses in the nurses' records, and I intend to receive the rest of that, and I don't see that it in any way - and under the Statute all that it says is:

"Pending the decision of the Divisional Court on the case stated no further proceeding shall be taken by the Commission with respect to the subject matter of the stated case but it may continue its inquiry into matters not in issue in the stated case."

The subject matter of the stated case is what is it to be in my report.

MR. LABOW: Thank you, Mr. Commissioner.

THE COMMISSIONER: Thank you. All right, anything else? Yes Mr. Shinehoft?

MR. SHINEHOFT: Just one point Mr. Commissioner, and I assume it goes without saying that the fact that we do not oppose the stating of the







D 4

1

2

3

4

case is not necessarily, or in any way to be construed that we disagree with the ruling that you originally made.

5

6

7

THE COMMISSIONER: I certainly hope we get some help from the Divisional Court I can tell you, it is going to be awkward if you all agree I am wrong, not that that hasn't happened before.

8

9

10

MR. YOUNG: It is not happening now Mr. Commissioner. The Police and their Counsel agree with your decision and support it entirely.

11

THE COMMISSIONER: Yes.

12

13

MR. YOUNG: If indeed you feel it is appropriate to state the case they will not object.

14

15

MR. SHINEHOFT: And this goes without saying as far as the Counsel for parents is concerned.

16

17

THE COMMISSIONER: Yes, all right.

MR. SCOTT: I don't want to be polled on this.

18

19

THE COMMISSIONER: No.

20

Mr. Brown, I am going to call on Mr. Lamek just to see if he has any comments he wants to make. Have you anything you want to say?

21

22

MR. LAMEK: No, I don't think there is anything I can add Mr. Commissioner.

23

24

THE COMMISSIONER: No, all right.

25





D 5

1

2

Mr. Brown, you have some concern?

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MR. BROWN: Following up on

Mr. Scott's points perhaps there are two matters.

First of all one of the major concerns with the

ruling was that you identified persons. That is not

necessarily apparent in the language that you have

used and perhaps the language could be included

towards the end.

THE COMMISSIONER: Any named person,

all right I will change that, any named person or

persons. All right:

"Was I right in determining that the  
Terms of Reference of this Commission  
entitle me subject to the qualifi-  
cations I have set forth to express  
my opinion upon whether the death of  
any child was the result of the  
action accidental or otherwise of  
any named person or persons."

MR. BROWN: The second point is with  
regard to the language accidental or otherwise. You  
may not like the use of the word deliberate, but I  
would certainly prefer that some word be included  
which deals with the matter of intent.

THE COMMISSIONER: Well, conscious,





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

D 6

accidental or conscious, will that assist you?

Accidental, either accidental or not accidental, that is what I mean.

MR. BROWN: I know that is what you mean and I wanted --

THE COMMISSIONER: If somebody fills a syringe and puts it in the baby's vein that is not accidental, ordinarily, he knows what he is doing.

MR. BROWN: Simply for a matter of clarification I would prefer the language to be accidental or intentional.

THE COMMISSIONER: Well intentional has another problem, I am not going to say they have intentionally, because then it can be argued intentionally that I am using Section 212 of the Criminal Code which I am not. I don't mean intentional in that sense, I mean that it was conscious, that they knew what they were doing, that's all.

MR. BROWN: That is accidental and conscious. I was simply asking that the distinction be drawn more clearly rather than falling under the word otherwise, or perhaps that all three could be put in, accidental, conscious or otherwise.

MR. LAMEK: Mr. Commissioner, Miss Cronk approves of it, I don't know whether Mr. Brown







1

2

will, would knowingly or unknowingly help.

3

4

THE COMMISSIONER: That might help,  
knowingly or unknowingly.

5

MR. BROWN: Yes.

6

7

THE COMMISSIONER: Does anybody object  
to that word, knowingly or unknowingly? Yes, all  
right.

8

9

10

11

12

MR. TOBIAS: Mr. Commissioner, does  
the inclusion of that phrase knowingly or unknowingly  
not bring us awfully close to the whole issue of  
intent, because I have concern about the question  
of intention?

13

14

THE COMMISSIONER: It is set forth  
in my Reasons and I said:

15

16

17

"Subject to the qualifications I have  
set forth ..."  
and those are the qualifications that are set forth  
in my Reasons.

18

19

20

21

22

23

24

25

MR. TOBIAS: I think we should  
remember though that in the original question that  
you posed to Counsel that you invited written sub-  
missions on, that you did not in the phrasing of that  
question indicate that you had any intention of going  
into the question of intent. I remind you what you  
asked was, whether or not the Terms of Reference





1  
2 entitled you, if you reach the conclusion that the  
3 death of any child was the result of the action of  
4 any person or persons, to name such persons, that is  
5 what you invited submissions on and that is the  
6 phraseology you used in your Reasons for Decision.

7 THE COMMISSIONER: I did say that I  
8 intended to go into whether it was accidental or not.  
9 Because it was perfectly clear to me by that time  
10 that that was an issue, the accident was an issue and  
11 I had to deal with it.

12 MR. TOBIAS: I don't object to the  
13 word "accidental", I want to steer clear of the  
14 intent issue. Because as you say that has a specific  
15 meaning under the Criminal Code and gets into the  
16 entire question of whether or not you are acting in  
17 accordance with the Terms, you are not supposed to  
18 determine criminal or civil responsibility.

19 THE COMMISSIONER: Well, I may as well,  
20 if I am wrong, I may as well be told because I do  
21 intend to determine, if I can, whether it was an  
22 accident or whether it was not. If it was not it  
23 means that the person who did it knew that at the time  
24 he, and I use the word he deliberately, was administer-  
25 ing an overdose of digoxin to the child, that's all.  
If I can't do that I want to be told that I can't do





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

that by the Divisional Court. Yes?

MR. BROWN: There is one final matter just so that there is no prospect that I have misled you as far as our intent in future proceedings. Mr. Labow raised the question of whether or not stating the case on this point would have the effect of staying the proceedings. It is certainly not our intention that that be the case. Nonetheless it is my submission that if the Divisional Court should find that you are not authorized in your report --

THE COMMISSIONER: I will be the first, I will be the first, if they find that you will find I will be the first because I am rather anxious to get this matter completed.

MR. BROWN: I appreciate that, there is no difficulty with the report, but it would be my submission that if you cannot do that in the report that may affect the admission of certain evidence.

THE COMMISSIONER: It may, you are quite right, you are quite right.

MR. BROWN: At that particular point if questions are put to various witnesses in that very unknown territory it would certainly be my intention at that point to object to the question.

THE COMMISSIONER: Yes. Well it







1  
2 depends. You see there is the remote possibility,  
3 first of all that the Divisional Court might find me  
4 wrong and that some other Court might find them wrong  
5 too, so we have to consider that problem as well.  
6 While they are playing around with the question I  
7 intend to get on with this Inquiry and I am going to  
8 use whatever influence I have to get these matters  
9 heard on a Friday so it won't delay us in getting on  
10 with these matters.

11 MR. BROWN: I appreciate that. I  
12 don't want to --

13 THE COMMISSIONER: I understand your  
14 point. If in the final determination I cannot name  
15 names I am not going to be that much interested in  
16 the evidence I can assure you of that.

17 MR. BROWN: Well, you may not be  
18 interested in the evidence, but this is a public  
19 inquiry.

20 THE COMMISSIONER: Yes?

21 MR. BROWN: If what you are able to do  
22 is to name names, or if the present position is that  
23 you can name names it has been our submission that is  
24 quite akin to criminal proceedings.

25 THE COMMISSIONER: Yes.

MR. BROWN: And a person is not afforded





1  
2 any of the protection that it is normally afforded  
3 under the criminal proceedings. Therefore, it would  
4 be my submission that if certain questions are put to a  
5 witness which perhaps are more appropriate in a  
6 criminal procedure I would object to their admission.

7 THE COMMISSIONER: That is an  
8 entirely different question, that is an entirely  
9 different question, that may well be a Constitutional  
10 question and I have not, in my Reasons, I did not deal  
11 with that. If you want to bring that up at any  
12 particular time you are entitled to do it. I have  
13 certainly not dealt with that question. That question  
14 has not arisen, it may not arise but if it does arise  
15 we will deal with it in just the same way as the  
16 question of notice.

17 MR. BROWN: That is fine, I just wanted  
18 to apprise you of our position that notwithstanding  
19 our desire to have the hearing continue that there may  
20 well be circumstances in which we do make objections.

21 THE COMMISSIONER: That is right.

22 MR. BROWN: On admission of that  
23 evidence.

24 THE COMMISSIONER: That's right. Is  
25 there anything else?

MS. KITELY: I would like to adopt





1  
2 Mr. Brown's last comment and I have a further comment  
3 too, if you have enough influence to have us heard on  
4 Friday --

5 THE COMMISSIONER: I don't know that I  
6 have, I just said I am going to try.

7 MS. KITELY: You are going to try?

8 THE COMMISSIONER: Yes.

9 MS. KITELY: Could you try, sir, to  
10 have this heard before Phase 1 is completed? I don't  
11 know what the timing is on either Phase 1 and the  
12 Divisional Court, but in the ordinary course --

13 THE COMMISSIONER: I think that would  
14 be nice to have it heard as soon as possible. The  
15 trouble is though, and this I now go back in history  
16 to the days when I was a trial judge, I had any number  
17 of people appear on motions before me and they said,  
18 now, this is a matter of supreme urgency and we want  
19 you to drop everything else and get the judgment out  
20 immediately, we don't want any of your delay usual sort  
21 of thing. So I would stay up all night, give them the  
22 appropriate, well, not the appropriate, give them  
23 judgment and two and a half years later I would read  
24 that leave was either granted, or refused, to go to  
25 the Supreme Court of Canada. So that sort of thing  
doesn't mean an awful lot. We can get it through the







1  
2 Divisional Court then we have to worry about the Court  
3 of Appeal, and then for all I know somebody is going  
4 to try to take it to the Supreme Court of Canada. I  
5 can't do anything like that, all I can say is that I  
6 intend to carry on with this hearing, and exactly what  
7 Mr. Justice Krever did, he produced his report before  
8 the results came down from the Supreme Court of Canada,  
9 I think that is right. At any rate, he didn't stop  
the hearing, he carried on.

10 MS. KITELY: I have been listening to  
11 you long enough, sir, to learn one thing we take it  
12 one step at a time, and I see only the Divisional  
Court, I don't see others.

13 THE COMMISSIONER: Yes.

14 MS. KITELY: My concern is that it is  
15 not clear that all of us will be here for Phase 2, and  
16 in my submission --

17 THE COMMISSIONER: You mean, some of  
18 us might be dead.

19 MS. KITELY: I wasn't going to go quite  
20 that far, sir. It would seem logistically extremely  
21 difficult if some of us were --

22 THE COMMISSIONER: You are quite right,  
23 it would be convenient if we had an end to the  
24 litigation but I can't promise you that because I don't  
25





1

2

3

4

know, anybody, any party to these proceedings will have the right to take it on if they don't like what the Divisional Court has said.

5

MS. KITELY: I appreciate that.

6

THE COMMISSIONER: So all we will do is do the best we can.

7

MS. KITELY: Thank you.

8

THE COMMISSIONER: We will get it on as soon as we can. Is there anything else? I think we will take a break now.

10

11

MR. TOBIAS: Mr. Commissioner, just before we do, sir, if we could just clarify for me the precise changes you have made.

12

13

14

THE COMMISSIONER: I am going to give Reasons, I will be giving Reasons in about half an hour. I will tell you the way it is now:

15

16

17

18

19

20

21

"Was I right in determining that the Terms of Reference of this Commission entitle me subject to certain qualifications I have set forth to express my opinion upon whether the death of any child was the result of the action, knowing or unknowing, ..."

22

It is an adjective, not an adverb:

23

"... of any named person or persons."

24

MR. TOBIAS: Thank you Mr. Commissioner.

25

- - - -





E/BN/ak

1

2

3

THE COMMISSIONER: I will give judgment, I think, then. Yes?

4

5

6

MR. OLAH: Just one thing. I fairly should point out that there is a judicial review pending of my case also.

7

8

9

THE COMMISSIONER: Oh yes, I understand that, but that is none of my business. You take that to the Divisional Court.

10

11

12

13

MR. OLAH: Right, yes, but I just wanted to be sure.

14

15

16

17

THE COMMISSIONER: There is no question you have got that, but that is not before me. I am the respondent.

18

19

20

MR. OLAH: Yes, I realize that, but all I am pointing out is if that really is a parallel action, and hopefully that we can avoid that by simply having all the matters heard at once on the stated case, if at all possible.

21

22

23

24

25

THE COMMISSIONER: Yes, thank you. I think we will take a break now. When are you going to be ready?

MS. CRONK: We are ready, sir.

THE COMMISSIONER: Are you ready now? Well, I think the sensible thing would be to take 20 minutes now, but I think we will make it at







1  
2 11:15 precisely, I will come in and  
3 I will give judgment in this matter, and then we will  
4 hear your witness.

5 MS. CRONK: Fine, sir.

6 THE COMMISSIONER: All right.

7 ---Short recess.

8 ---Upon resuming.

9 THE COMMISSIONER: During the recess,  
10 some knowing person referred me to the problem of  
11 "knowingly" and "unknowingly" in the Criminal Code,  
12 so I have changed it back to accidental or otherwise,  
13 being the best I could think of at the moment.

14 I have been asked to state a case  
15 with respect to certain matters that have arisen in  
16 the course of this Inquiry. One of these concerns  
17 the possible content of my report, and two  
18 concern the Notice to be given under Section 5(2)  
19 of the Public Inquiries Act.

20 I agree to state a case with respect  
21 to the first; I decline to state a case with respect  
22 to the latter two. I will shortly state my reasons  
23 as follows.

24 It is my view that although the first  
25 question might turn out to be academic, we have  
heard and intend to hear more evidence of the





1  
2 association or lack of association with the care of  
3 the children and the opportunity to administer to  
4 them digoxin overdoses of each member of the Trayner  
5 team. It is my intention, unless I am directed  
6 otherwise, to weigh that evidence and reach a  
7 conclusion whether any one or more of that team  
8 contributed to the cause of death of any one of the  
9 children.

10 As I said in my reasons, I think it  
11 appropriate that each member of the team knows the  
12 extent of her potential exposure so that she can  
13 deal adequately with evidence and argument. Also,  
14 if I am wrong, it is clearly preferable that I be  
15 advised now rather than after the report is released.

16 I am not, however, entirely happy  
17 with the form of the stated case, particularly with  
18 the use of the words "deliberate" and "negligent",  
19 which may have legal connotations. In my reasons for  
20 judgment on the matter, I pose the question thus:  
21 does the first issue require or entitle me, if I  
22 should reach the conclusion that the death of any  
23 child was the result of the action of any person or  
24 persons, to name that person or persons, and I  
25 answered the question in the affirmative, subject  
to certain qualifications set forth in the reasons.





E4

1  
2  
3 On further reflection and in order to  
4 make clear exactly what is my present intention, I  
5 will pose the stated case as follows. Was I right in  
6 determining that I am entitled in my report on this  
7 Commission, subject to certain qualifications I have  
8 set forth, to express my opinion upon whether the  
9 death of any child was a result of the actions,  
10 accidental or otherwise, of any named person or  
11 persons. There are two requests for a stated case  
12 on the Notice question. One by four counsel  
13 representing nurses individually or collectively,  
14 and one by Mr. Olah representing Janet Brownless.

15 The first asked certain questions as  
16 to the form and effect of the Notice under Section 6,  
17 Subsection (2), and Mr. Olah has asked for specific  
18 relief for his client and is supplemented by a  
19 separate application for judicial review. It is  
20 clear from Section 6(2) that I am not bound to state  
21 a case unless directed to do so by the  
22 Divisional Court. However desirable or convenient  
23 for me it might be to have the questions posed and  
24 the first Notice answered, in my opinion, the stating  
25 of a case in either application in these circumstances  
is most inappropriate. With respect, I think the  
applicants misconceive the nature of the proceedings.







E5

1  
2 This is an Inquiry, not a trial. There is no charge  
3 against anyone and there may never be.

4 I find no difficulty in interpreting  
5 Section 5(2) of the Act. I am forbidden from making  
6 a finding of misconduct against anyone unless that  
7 person has had reasonable Notice of the substance of  
8 the misconduct alleged against him and has been  
9 allowed to be heard during the Inquiry. I have and  
10 will continue to have that injunction in mind, but the  
11 time for its application has not yet arrived and may  
12 never arrive.

13 If the question does arise, the manner  
14 of applying the subsection can then be considered in  
15 light of the circumstances, but the Divisional  
16 Court cannot be expected to answer hypothetical  
17 questions and give answers which may be unnecessary  
18 or inadequate for the occasion.

19 Certain persons have sought and been  
20 granted standing, and their counsel have been granted  
21 public funding because of the possibility that the  
22 evidence might at some point bring Section 5(2) into  
23 play. I can think of no other way of satisfactorily  
24 running the Commission. I gave reasons for rejecting  
25 Mr. Olah's earlier motion. I need not repeat those  
reasons except to say that both the requests now





1  
2 before me in my opinion are premature. Accordingly,  
3 I will not state the cases asked or any case on the  
4 subject. Any party has, of course, the right under  
5 Section 6(2) to take the matter further.

6 All right, is there anything more  
7 before we proceed? All right, Miss Cronk?

8 MS. CRONK: Thank you, sir. Sir,  
9 our next witness is Ms. Carol Browne. I will call  
10 Ms. Carol Browne to the stand.

11 MR. PERCIVAL: Mr. Commissioner,  
12 may I raise a matter, and I think that I am assured  
13 by counsel and I just want it clear for the record,  
14 I gather from what Mr. Lamek and Ms. Cronk has  
15 indicated to me, that this particular witness will  
16 be called on two occasions because there seems to  
17 be some overlap, at least on the information that I  
18 have, in relation to it, and that the questions at  
19 least in this phase of the Inquiry would be up to the  
20 time of the police involvement and not beyond.

21 Do I have assurance, though, that she  
22 will be called a second time?

23 MS. CRONK: Well, Mr. Commissioner,  
24 we have discussed the matter with Mr. Percival, and  
25 what Mr. Lamek and I have indicated to him is that  
the witness is being called at the present time only





1  
2  
3 with respect to those matters relating to Phase 1,  
4 that is, cause of death, and should it become necessary  
5 in the future to recall the witness, we will certainly  
6 consider the matter at that time.

7 I can say that there has not been a  
8 decision made by Mr. Lamek or myself to recall her  
9 subsequently, but should it prove necessary or  
10 should Mr. Percival or any other counsel have questions  
11 that they feel appropriate to be put to this witness  
12 concerning Phase 2, that is obviously a matter we  
13 can deal with.

14 MR. PERCIVAL: I guess we will have  
15 to come to it when we come to it.

16 THE COMMISSIONER: Well, I prefer  
17 not to have witnesses come back.

18 MR. PERCIVAL: I understand that.

19 THE COMMISSIONER: I have no idea  
20 what this witness knows. You know better than I do.

21 MR. PERCIVAL: As I said, we will  
22 come to it when we come to it, and Mr. Commissioner  
23 will have to make a ruling at that point. Thank you,  
24 sir.

25 THE COMMISSIONER: All right, thank  
you, sir.

MS. CRONK: Ms. Browne.







E8

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

THE COMMISSIONER: I may say on the stated case, I will prepare it over the weekend and it will probably be available on Monday.

CAROL BROWNE, Sworn

DIRECT EXAMINATION BY MS. CRONK:

Q. Thank you, Ms. Browne.

Ms. Browne, as I understand it, you obtained a Bachelor of Science degree and your Registered Nursing degree from the University of Toronto in 1970; do I have that correctly?

A. That is correct.

Q. And thereafter you joined the nursing staff of the Hospital for Sick Children as a general duty nurse on a medical ward, that is to say, a non-cardiology ward; do I have that correctly?

A. That is correct.

Q. In August of 1971, as I understand it, you left the Hospital for Sick Children and accepted a position as a lecturer and a clinical instructor for second and third year nursing students at the University of Toronto, School of Nursing?

A. That is right.

Q. And you remained in that position, as I understand it, for a year?

A. Yes.





E9

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. In August of 1972, you returned again to the Hospital for Sick Children, this time as well as a general duty nurse, but in the Intensive Care Unit?

A. That is correct.

Q. And you remained in the Intensive Care Unit in that capacity until August of 1973?

A. True.

Q. In the years 1973 to 1974 you undertook and successfully completed a Masters of Nursing degree at the University of Pittsburgh; do I have that correctly?

A. That is correct.

Q. And then as I understand it you spent the next five months as a lecturer and clinical instructor at the School of Nursing, Mississippi College in Mississippi?

A. Correct.

Q. And in June 1975 you returned again to the Hospital for Sick Children, this time in the position of a pediatric clinical nurse specialist in the Division of Pediatric/Cardiology; is that correct?

A. That is correct.





1

2

E10

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. You have, as well, Ms. Browne, authored or co-authored a number of publications in the areas of pediatrics and pediatric cardiology and have co-chaired or participated in a number of conferences and workshops on pediatrics oriented issues; do I have that correctly?

A. That is correct.

Q. I do not propose to detail those at length, Ms. Browne, but as I understand it, simply to fill out the current state of affairs, you left the employ of the Hospital for Sick Children in February of this year; do I have that correctly?

A. It was the end of January.

Q. I am sorry, end of January.

A. Yes.

Q. In March, beginning of March 1983 you assumed duties as a clinical nurse specialist with the Public Health Department here in Toronto; do I have that correctly?

A. That is correct.

Q. During the years 1975 to 1982 inclusive, Ms. Browne, did you hold any position at the Hospital for Sick Children other than that of clinical nurse specialist in the Cardiology Department?

A. No.





Ell

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Ms. Browne, you have been kind enough to provide to me a copy of your curriculum vitae, which sets out in more detail the numerous papers you have authored and the workshops in which you have participated. Could you just identify it for me as your curriculum vitae?

A. I would, and there is one correction.

Q. All right. Could you tell us what the correction is, Ms. Browne?

A. It is my position as a pediatric clinical nurse specialist in cardiology, and that was until the end of January 1983 rather than August.

MR. YOUNG: I am sorry, I cannot hear the witness.

THE WITNESS: I am sorry, it was a date error. It reads August 1983 and it was January 1983.

MS. CRONK: Q. You are referring, Ms. Browne, to the last time entry on the bottom of the first page?

A. That is correct.

MS. CRONK: Is that any better, Mr. Young?

MR. PERCIVAL: That microphone does







1

2

not seem to be working, Ms. Cronk.

3

THE COMMISSIONER: I think it is

4

on. I think it is coming through all right now.

5

MS. CRONK: Try it again.

6

THE WITNESS: Is that better?

7

MR. PERCIVAL: Yes, thank you.

8

MS. CRONK: Could that then be

marked, sir, as the next exhibit?

9

THE COMMISSIONER: Exhibit 290.

10

11

---EXHIBIT NO. 290: Curriculum Vitae of Carol  
Browne.

12

MS. CRONK: Q. Ms. Browne, could

13

you help me first with a perhaps practical matter.

14

There are others before this Commission who are

15

perhaps familiar with you under a different name.

16

As I understand it, Browne is your married name; is

17

that correct?

18

A. That is correct.

19

Q. What was your maiden name,

Ms. Browne?

20

A. It was Carol Putherbough.

21

Q. Thank you. Could you briefly

22

describe for us, Ms. Browne, the nature of your

23

duties as a clinical nurse specialist with the

24

25





1  
2  
3 Cardiology Department at the Hospital for Sick  
4 Children?

5 A. It was the first of a position  
6 created in Cardiology. It was initiated by Dr. Rowe,  
7 who felt there was a need for greater continuity  
8 for families moving from one area of the Hospital  
9 to another. Many of the cardiology patients moved  
10 from ward area to the operating room to Intensive  
11 Care and back to ward areas.

12 So he had approached the Nursing  
13 Administration for a person to do that. I had come  
14 out of a Masters program that had focused on nursing  
15 care of children, so my concern was what happens  
16 to children in hospital.

17 My focus in my clinical work had not  
18 specifically been cardiology but pediatrics. So my  
19 focus in that position was to look at how do you  
20 support children and families in hospital.

21 -----  
22  
23  
24  
25





BmcB.jc

F

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

I did that through educational process of both the child, family and the staff in dealing with those issues. I was involved clinically on a one-to-one with children and families, would follow children to the Operating Room and to the Intensive Care Unit and see them again on the ward.

So, it was a liaison type of position so that there was one consistent person available to the family through that admission.

Q. Ms. Browne, you have told us that the position was a newly created one when you assumed it. When was the position, to the best of your knowledge, created at the Hospital?

A. When I came into that position, which was the middle of June, 1975.

Q. All right. And you have told us, as I understand it, that as you saw it the focus or thrust of the position included working both with the staff and supporting children and families during the duration of a particular child's stay in the Hospital; do I have that correctly?

A. That is correct.

Q. When you referred to working with the staff, were you referring to the nursing staff as they might be involved with any given particular patient?







F.2

1

2

A. Yes.

3

Q. What proportion of your time

4

on average, Ms. Browne, would have been spent working

5

directly with the nursing staff and what proportion

6

directly with the families or is it possible to break  
it down in that way?

7

A. It is difficult to be accurate.

8

If I can put it on a continuum for you. When I first

9

started in cardiology, because of my need to become

10

more familiar with the stresses for the children and

11

families, I would say that it was probably an 80/20.

12

So, it was 80 per cent of my time was spent with the

13

children and families, 20 per cent on staff-related

14

issues. As the load became heavier, that became less

15

reasonable and my time then in working through the

16

nursing staff with the families became greater, so,

I would say a 60/40.

17

Q. And would that have been the

18

case, Ms. Browne, by the summer of 1980?

19

A. Yes.

20

Q. As a clinical nurse specialist

21

in that department, were your areas of responsibility

22

confined to cardiac patients first on Ward 5A and

23

then subsequently on Wards 4A/B when the cardiology

wards were relocated?

24

25





F.3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. Yes, but it wasn't only that area because I did see cardiology patients wherever they were in the Hospital. So, that included the neonatal unit and the ward, be it 5A or 4A/B was full, the children were admitted to other areas of the Hospital.

Q. Would you have any involvement then with cardiac children, patients in for example the Intensive Care Unit or the Operating Room?

A. Yes.

Q. All right. To whom, Ms. Browne, did you report in your position?

A. To the Assistant Director of Nursing.

Q. The period of time as you know with which this Commission is most particularly concerned is that 9-month period which commenced in July, 1980 and concludes in the latter part of March, 1981. During that period of time was there more than one clinical nurse specialist in the Department of Cardiology?

A. Yes, there was.

Q. All right. Can you tell us, were there two, were there three?

A. There were two.





P.4

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q All right. And when was the second clinical nurse specialist introduced to the department?

A I believe it was the beginning of June.

Q Of 1980?

A Of 1980.

Q And was the second clinical nurse specialist a member of that department throughout the 9-month period with which we are concerned?

A Yes.

Q Were here duties akin to your own as you have described them to us?

A Yes.

Q Could you tell us the name of the second clinical nurse specialist?

A Her name was Janet Beed.

Q Beed?

A Yes.

Q Thank you. In terms of your own duties and responsibilities, Ms. Brown, what were your normal hours of work at the Hospital?

A I generally started at 7:30 in the morning and would finish usually between six and seven in the evening.





F.5

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Were you on occasion required to work during the evening or the night shift at the Hospital?

A. I wasn't required to.

Q. All right. Did you do so on occasion?

A. There would be occasions, yes.

Q. What about weekends, Ms. Browne?

A. Occasionally.

Q. All right, but not normally?

A. Not normally.

Q. All right. We know, Ms. Browne, that in April, 1980, the cardiology ward then in the hospital Ward 5A was relocated if you will towards 4A/B and the evidence has been that that occurred at the beginning of April, 1980. After that move had been effected, did you have any particular duties or responsibilities on Wards 4A/B other than the general responsibilities that you outlined a few moments ago?

A. Do you mean had my duties changed in any way?

Q. Yes.

A. No.

Q. You are right, that was a better way to put it.







P.6

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

How often on average, Ms. Browne, during the course of a working week or a working month would you be required to be physically present on Wards 4A/B to consult with the nursing staff?

A. Could you say that again?

Q. How often in the course of a normal working week would you physically be present on Wards 4A/B to consult with the nursing staff?

A. Every day during that week.

Q. Every day?

A. Yes.

Q. Did your responsibilities and duties extend at any point to direct involvement in the day-to-day care of patients on Wards 4A/B?

A. Would you repeat that?

Q. Yes. Did your responsibilities extend at any point to the day-to-day care of patients on Wards 4A/B?

A. In a limited way.

Q. All right. In what way was that?

A. I would deal with the individual nurse who was working with the family and we might sit down with the family together, or look at the particular problems of nursing care together.

Q. Were you involved at any point





F.7

1

2

3

4

then, Ms. Browne, in what perhaps could best be described as the daily bedside care of the children or infants who were patients on Wards 4A/B?

5

6

A. I would say that I had no responsibility in that, but served as a consultant for the nursing staff.

7

8

Q. Thank you.

9

10

11

12

13

14

A. Okay.  
Q. Ms. Browne, we have heard in evidence something about various nursing concepts or systems which we are told applied on Wards 4A/B during the 9-month period with which we are concerned. In the course of your own duties did you become familiar with the concept of team nursing as it applied to Wards 4A/B?

15

16

17

18

A. Yes, I did.

19

20

21

22

23

24

25

Q. Are you in a position to briefly outline for us what the concept of team nursing involved from the nursing perspective?

A. Briefly.

Q. If you would.

A. Okay. I will speak to it at that point in time because there are different nursing concepts in terms of team nursing, but in terms of Ward 4A/B, you would have a team of





P. 8

1

2

3

4

5

6

7

8

9

10

11

nursing assuming care for a group of patients for a particular shift; of that team there would be one nurse and it would be a registered nurse who would be designated the team leader. So, she would assume administrative responsibilities, if you will, for that tour of duty. She would do the patient assignments, she was ultimately responsible for what her team members did, but the registered nurses on that team would assume complete patient care, they would do total patient care for the patients assigned to them.

12

13

14

The team leader often would do the medications for the RNA or any procedures that the RNA was not able to do.

15

16

17

Q. When you say, Ms. Browne, that the registered nurses who were members of any given team assumed total care, I think that was the language you used, for any particular patient?

18

19

20

A. Yes.

21

22

23

24

25

Q. Can you elaborate for us as to what you mean by that?

A. Well, the registered nurse would do everything that was required for that patient.

Q. All right.

A. Within that tour of duty. That







F9/ak

1

2

would include medications, treatments.

3

Q. And I assume feedings?

4

A. And chartings and feedings, yes.

5

6

7

8

9

A. Yes, and then she would report to the team leader on the care that she had given.

10

11

12

13

14

Q. And we have heard as well, Ms. Browne, of a concept or system of nursing described as shared care nursing. In the course of your duties and exposure to Wards 4A/B did you become familiar with that concept?

15

A. Yes.

16

17

Q. Could you explain again for us from the nursing perspective what was meant by shared care nursing duties?

18

19

20

21

22

A. It was a more concentrated assignment in terms of nurse/patient ratio. So, one nurse would have two or three children to care for as opposed to four or five, which might have been a regular assignment.

23

24

25

Q. And in the shared care system, would an individual nurse ever be assigned more than





1

2

three children?

3

A. Not by my definition.

4

Q. All right. In reality perhaps

5

I can put that question then to others who were

6

involved more directly in the day to day care of a

7

child?

8

A. Yes.

9

Q. If a particular nurse then was

10

assigned two or three children on a shared care basis,

11

did that necessarily mean that another nurse would be

12

involved as well in their care or was she responsible

13

again for the total care of all of the patients that

14

were assigned to her on that basis?

15

A. She would be responsible for

16

their total care and would be responsible that some-

17

body would relieve her of that responsibility while

18

she took breaks or had to leave the room for any

19

reason.

20

Q. And when any one individual

21

nurse was assigned shared care duties was there at

22

the same time assigned another nurse whose duty it

23

was to relieve the principal shared care nurse if

24

she needed to take a break or have her lunch?

25

A. Yes.

Q. So, at the outside of any





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

given shift would an individual nurse know the  
identify of the other nurse who was assigned to  
relieve her as the occasion arose?

A. Yes.

Q. In addition to that, would  
there be from time to time to the best of your know-  
ledge ad hoc arrangements whereby one nurse might  
request another to relieve her, although, the nurse  
being requested to do that was not formally assigned  
that duty?

A. If something came up and she  
needed to leave the room, yes.

Q. We have heard something as  
well, Ms. Browne, about a nursing system described  
as constant care nursing. Are you familiar with  
that system as it applied on Wards 4A/B?

A. Yes.

Q. Could you as well explain from  
the nursing perspective what was involved in constant  
care nursing care duties?

A. Constant care nursing meant  
that one nurse was assigned to one child and that  
there would always be a nurse with that child.

Q. Was the nurse who was assigned  
constant care duties responsible again for the total





1

2

care of that particular patient?

3

A. Yes.

4

Q. Was there a backup nurse

5

assigned, as you have described it, in the shared

6

cared nursing situation for the purposes of relieving

7

as the occasion arose any nurse who had constant

8

care duties?

9

A. Yes.

10

Q. Would that be a specific

11

individual assigned at the beginning of any particular  
shift or was that an ad hoc arrangement?

12

A. It was usually assigned and

13

it was quite often another nurse in the room; if

14

indeed that was arranged it might have been the team  
leader.

15

16

Q. I'm sorry, if it was arranged

17

in advance the assignment was determined by the  
team leader?

18

A. Yes.

19

Q. And was that true as well of

20

the shared care nurses, if those duties were assigned,  
were they assigned by the team leaders?

21

22

A. Usually.

23

Q. Were you familiar as well as

24

part of your duties and responsibilities with the

25







1  
2 Cardiology Department, Ms. Browne, with what has  
3 been described as a problem oriented medical records  
4 system?

5 A. Yes.

6 Q. The initials of that we have  
7 heard in prior evidence, in fact is it called the  
8 POMR system?

9 A. Yes.

10 Q. Could you briefly outline for  
11 us what is intended to be ---

12 THE COMMISSIONER: I'm sorry, I haven't  
13 got it. It is Problem Oriented Medical Record?

14 MS. CRONK: I'm sorry, sir, yes.

15 THE COMMISSIONER: And that is POMR,  
16 is that it?

17 THE WITNESS: Yes.

18 THE COMMISSIONER: That is reasonable  
19 enough, I guess.

20 MS. CRONK: Q. Could you briefly  
21 outline for us, Ms. Browne, what is intended to be  
22 accomplished by the problem oriented medical records  
23 system that was in use?

24 A. I think the purpose of it was  
25 to make charting more effective and more succinct.  
So that in the care of a child as certain problems









1  
2  
3 arose those problems would be listed at the beginning  
4 of the chart with the number and as people charted  
5 then they would refer to that number in terms of the  
6 information they were relaying. How that process  
7 of recording differed from previous ways of charting  
8 at the Hospital, in my mind, was that it spoke to  
9 problems, so, it eliminated a lot of the standard  
10 type of recording in that the patient slept well,  
11 where, if there wasn't a change, with the problem  
12 medical oriented record, if things were stable with  
13 the child, there was no significant change, there  
14 might not be charting done in the progress note.

15 Q. Would it be fair then if I  
16 suggested that that particular system went to the  
17 nature of matters that were to be charted by nurses  
18 on any round of duty in the medical records of a  
19 particular child?

20 A. Yes.

21 Q. And when you said it was  
22 problem oriented, as the name of course suggests,  
23 if a child's condition had not altered, be it  
24 positively or adversely during the course of any  
25 given nurses' duties, which she in those circumstances  
be required to make any notation in the progress  
notes of the medical record at all?







1

2

A. No.

3

4

5

6

Q. If however the child's condition had improved, had changed in a positive way, is that something that you would have expected to be contained or noted in the medical record?

7

A. Yes.

8

9

10

Q. And similarly if there had been any adverse variation or change in the child's condition, is that something that should have been noted?

11

A. Yes.

12

13

14

Q. Was that system in place on Wards 4A/B from July of 1980 through to March of 1981?

15

A. Yes, it was.

16

17

Q. You have told us Ms. Browne, that in your position you reported directly to the Assistant Director of Nursing?

18

A. Yes.

19

20

21

22

Q. And I take it that the Assistant Director of Nursing would have been responsible to report directly to the Director of Nursing in the Hospital?

23

A. Correct.

24

25

Q. I am interested, Ms. Browne, in





1  
2 the hierarchy in an organizational sense that  
3 existed on Wards 4A, 4B during this nine-month period  
4 in terms of the nursing staff. Leaving aside the  
5 Director of Nursing and the Assistant Director of  
6 Nursing in the Hospital per se, could you outline  
7 for us what the organizational structure amongst the  
8 nursing staff was on the two wards?

9 A. Would you like me to do it  
10 down then from the Assistant Director?

11 Q. If you would, please.

12 A. Okay. From the Assistant  
13 Director of Nursing you had co-ordinators that were  
14 responsible for numbers of nursing areas; below the  
15 co-ordinators would fall the clinical nurse specialist  
16 as well as the evening and night supervisors; below  
17 them would be the head nurse. At that time there  
18 weren't assistant head nurses, so, it would be the  
19 head nurse and under her team leaders and at that  
20 time we had a teaching team leader and then you  
21 had the bedside nurses be R.N.'s and R.N.A.'s.

22 Q. Could you help me with a  
23 number of those positions? First dealing with the  
24 head nurses. We have heard that during the nine-month  
25 period there were two head nurses; one for 4A and  
one for 4B, does that accord with your knowledge of





1

2

the situation?

3

A. Yes.

4

5

Q. And what is what you have  
described as a teaching team leader?

6

7

A. It's a nurse whose duties are  
described in terms of orienting and educating the  
nursing staff on the ward area.

8

9

Q. Was there more than one teaching  
team leader assigned to those two wards?

10

A. No, there was one.

11

12

Q. And was that throughout the  
entire nine-month period?

13

A. Yes.

14

15

Q. Did that individual have  
active bedside nursing duties in addition to the  
teaching or the education role that she played?

16

17

18

A. At that point in time, if  
indeed we were short nursing-wise, she might be  
asked to carry a patient assignment.

19

20

21

-----

22

23

24

25





G/DM/ko

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. We have heard as well in prior evidence, Ms. Browne, that the Head Nurses on Wards 4A and 4B in the normal course of events worked day shifts as opposed to evening shifts, do I have that correctly?

A. That is correct.

Q. Who then in a practical sense on the night shift on Wards 4A/4B would be the most senior nurses who were physically present on the wards?

A. It would be the team leader.

Q. You have mentioned as well nursing co-ordinators and nursing supervisors, would any of those individuals have nighttime responsibilities on the wards to the best of your knowledge?

A. The nursing supervisors did cover the hospital on evenings and nights.

Q. In terms then specifically of Wards 4A/4B would a night supervisor specifically be assigned to those wards during the evening shift?

A. She would be assigned in terms of being responsible for what went on in those areas and would come by several times during that shift.

THE COMMISSIONER: Would the supervisor know, have particular wards, or would she have the whole







G 2

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

hospital?

THE WITNESS: Generally I think there were two supervisors on shift.

THE COMMISSIONER: For the whole hospital?

THE WITNESS: For the whole hospital.

THE COMMISSIONER: Would one of them, for instance, have specific duties with respect to Wards 4A/4B or would they both have the whole hospital?

THE WITNESS: No, they would divide the hospital.

THE COMMISSIONER: They do that themselves?

THE WITNESS: Yes.

MS. CRONK: Q. Do I have it then correctly, Ms. Browne, that the nursing supervisors, the two that you have just described, were responsible during the evening for coverage of the entire hospital between them, and that the co-ordinators assumed similar duties during the day shift?

A. Yes.

Q. So the nursing co-ordinator would not in the normal course of events be on duty during the evening shift?





1

2

A. Correct.

3

Q. Was there as well during that

4

nine month period, Ms. Browne, a clinical instructor  
assigned to Wards 4A/4B?

5

6

A. I don't believe the term

7

clinical instructor came into being until a later  
point in time, and it was a term used to replace the  
term teaching team leader.

8

9

THE COMMISSIONER: I am sorry, this

10

clinical nurse specialist that you have mentioned who  
was under the co-ordinators and above the supervisors,  
that is not your job I take it, or was it your job?

11

12

THE WITNESS: That is where we fit in  
in our organizational chart.

13

14

THE COMMISSIONER: I am sorry, you

15

were talking about some clinical nurses.

16

MS. CRONK: I am sorry, sir, there was

17

a different term, you are quite right.

18

THE COMMISSIONER: Well, I am lost.

19

MS. CRONK: It was a clinical

20

instructor and if I have understood --

21

THE COMMISSIONER: Is that the same

thing as a teaching team leader?

22

THE WITNESS: Yes.

23

THE COMMISSIONER: It is the same thing?

24

25

G 3





1

2

THE WITNESS: Yes.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MS. CRONK: Q. As I understand it, during that nine month period that was the same thing as the teaching team leader but later the title was changed, do I have that correctly?

A. Correct.

THE COMMISSIONER: A clinical --

MS. CRONK: Clinical instructor.

THE COMMISSIONER: Clinical instructor, thank you.

MS. CRONK: Q. Ms. Browne, you have told us that at approximately June of 1980 a second clinical nurse specialist was assigned to Wards 4A/4B, Ms. Beed; were any part of her duties concentrated on the evening shift, or did she like yourself work primarily days?

A. She worked primarily days.

Q. So I take it then that in the normal course of events no clinical nurse specialist would be present on either of Wards 4A/4B during the evening shift or on weekends?

A. Generally, that is correct.

Q. In your position with the Cardiology Department during this nine month period, Ms. Browne, were you required to familiarize yourself







1

2

with the policies and procedures which governed the  
Department of Nursing as outlined by the Department  
of Nursing during that nine month period?

4

5

A. I couldn't say specific to that  
nine months, that was a responsibility that came with  
employment in the hospital in an ongoing way.

6

7

8

9

10

11

Q. Once you commenced employment  
with the hospital then, I take it it was part of your  
duties to familiarize yourself with whatever policies  
set by the Department of Nursing were then in place  
concerning various wards in the hospital?

12

A. That is right.

13

14

Q. Did that include the particular  
policies which applied to Wards 4A/4B?

15

A. It would.

16

17

18

19

20

Q. Did you in the course of  
completing that general orientation with respect to  
the policies of Department of Nursing, have occasion  
to familiarize yourself with what is described as  
the: "Policy and Information Manual - Department of  
Nursing - the Hospital for Sick Children"?

21

A. Yes, I did.

22

23

24

25

Q. Ms. Browne, I am showing to you  
what has been described to me as part of the Policy  
and Information Manual set out by the Department of





1  
2 Nursing as it applied during the period 1977 through  
3 to the end of June, 1981. I tell you immediately that  
4 the bound version that I am showing you contains only  
5 extracts from that Manual, but would you take a moment  
6 please and examine it and tell me if you recognize it  
7 as the Manual which applied during that period? Have  
8 you seen this Manual before Ms. Browne?

9 A. Yes.

10 Q. To the best of your knowledge  
11 is it part of the "Policy and Information Manual"  
12 that applied during that nine month period?

13 A. It appears to be.

14 MS. CRONK: Could that then, sir, be  
15 the next exhibit?

16 THE COMMISSIONER: Yes, Exhibit 291.

17 --- EXHIBIT NO. 291: Extracts from "Policy and  
18 Information Manual -  
19 Department of Nursing -  
20 the Hospital for Sick  
21 Children", 1977-June 1981.

22 MS. CRONK: Q. Ms. Browne, I would  
23 ask you if you would please to turn to the second page  
24 of the bound version of the Manual which is a general  
25 index of the contents of the full Manual. For your  
assistance and that of the Commissioner and other  
Counsel, I would like to outline for you, sir, which  
portions of the general Manual have been included in





1

2

this bound exhibit.

3

4

Section 4 deals with "Death" and it is  
in part included in this exhibit.

5

6

Section 11 deals with the "Writing of  
Orders" and it is in part included.

7

8

Section 14 deals with "Medications"  
and it is reproduced in its entirety.

9

10

11

12

13

Section 15 deals with "Narcotics" and  
it is reproduced in its entirety.

Well indeed, sir, Section 16 through  
to Section 18, inclusive, dealing with "Special  
Procedures, Intravenous Therapy and Intravenous  
Medications" are all reproduced in their entirety.

14

15

16

Section 21 dealing with "Treatment"  
is reproduced in part.

Section 24, 25 and Section 28 have  
been reproduced in part.

17

18

19

20

21

The next 18 or so pages, Ms. Browne, of  
the exhibit before you represent a detailed index of  
the contents of the Manual. Inadvertently in the  
copying, Mr. Commissioner, page 14 of the detailed  
index was omitted and I just ask that you add it, sir,  
if you will, to your volume.

22

THE COMMISSIONER: Thank you.

23

24

25

MS. CRONK: Q. Ms. Browne, I ask you





1  
2 first to go, if you would, to the first page which  
3 follows the detailed index, the exhibit is not  
4 specifically paged because various sections of the  
5 Manual are sequentially numbered. The first page I  
6 am interested in is entitled "Policy and Information  
7 Manual" and it is by way of an introduction, do you  
8 have that?

8 A. Yes.

9 Q. The first two paragraphs of the  
10 introduction indicate, Ms. Browne, that the Manual had  
11 been prepared by Nursing and it was a combination of  
12 nursing policies of the Hospital for Sick Children  
13 and information relevant to nursing and that it was  
14 to be kept in each nursing area. To the best of your  
15 knowledge was a copy of this Manual kept on Wards  
16 4A/4B?

16 A. Yes.

17 Q. And similarly the second para-  
18 graph of the introduction indicates:

19 "It is the responsibility of each  
20 Nurse to familiarize herself with  
21 the contents of this Manual and to  
22 refer to it as necessary."

23 To the best of your knowledge, Ms.  
24 Browne, was each nurse working on Wards 4A/4B including  
25







1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

the registered nursing assistants who were assigned to those wards expected to be familiar with the contents of this Manual?

A. Yes.

Q. And we see then in the next two sections of the Manual, Ms. Browne, two Definitions, one which applies to the phrase "Qualified Nurse", and on my reading of the section the definition - I am sorry:

"This term is used throughout this Manual to refer to all categories of nurses: a Registered Nurse, Registered Nursing Assistant, ..."

Do I have that right, have I read that correctly?

A. Yes.

Q. And when we see the phrase "Qualified Nurse" throughout the body of the Manual it could be referring to a Registered Nurse, a Registered Nursing Assistant, an Student, a Nursing Technician or a number of other individuals, do I have that correctly?

A. Yes.

Q. And we then at the bottom of the page examine the definition of "Certified Nurse" we see according to the Manual:





1

2

3

4

5

It indicates:

6

7

8

9

10

11

12

13

14

A. Yes.

15

16

17

18

19

A. Yes.

20

21

22

23

24

25

"This term refers to a Nurse who has received special training in order to become competent in a special procedure."

"She has been tested, and has received a special procedures certificate."

Would I be interpreting it correctly, Ms. Browne, if I again took the phrase "Certified Nurse" to refer both to a Registered Nurse and potentially as well a Registered Nursing Assistant provided that either had obtained the special certificate that is mentioned in the definition?

Q. I would ask you then in terms of the substance of the Manual to turn first if you would to Section 30.07, which is the second last page contained in this exhibit, do you have that?

Q. The section is entitled as it appears: "Clinical Nurse Specialist in Pediatric Cardiology" and Sub-section 3 of the Manual sets out what are described as major responsibilities of a clinical nurse specialist. I take that to be a





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

description of what were considered to be your major responsibilities, Ms. Browne, do I have that correctly?

A. Yes.

Q. Could you review those briefly for us and tell us whether or not in your judgment they represent what in practical terms were your major responsibilities as a Clinical Nurse Specialist in the Cardiology Department?

A. Would you like me to go through them?

Q. Yes, if you would not mind, just take a moment to read them and tell us whether they in your judgment represent the major responsibilities which you felt you had?

A. Yes.

Q. Other than the responsibilities specifically set out, are there others which in your view, Ms. Browne, applied to your position during the nine month period of time that we are concerned with?

A. The other responsibilities I had concerned education in terms of general responsibility to other nurses in hospital areas around the pediatric issues, and also a responsibility to look at research issues with this patient population.

Q. By that do you mean that you







1

2

actively engaged in research, or was it part of your  
job to ask others to consider matters as they arose?

3

4

A. No, it was to actively engage  
in.

5

6

Q. Did you from time to time do  
that?

7

A. Yes.

8

9

Q. You mentioned earlier in  
describing your terms of reference, or your job  
responsibilities, Ms. Browne, as I understood it,  
that you served as a liaison or a link between  
nursing and cardiology, do I have that correctly?

12

A. Yes.

13

14

Q. Did you have direct contact with  
any of the staff cardiologists on an ongoing basis  
that were assigned to Wards 4A/4B?

15

16

A. I had a contact with all of  
them; the extent of that contact varied with who was  
on service.

18

19

Q. Did you in any sense report to  
any member of the cardiology staff, cardiology medical  
staff as distinct from nursing?

20

21

A. In a hierarchical sense, no,  
in a reality sense I did meet regularly with Dr. Rowe.

22

23

Q. Did you meet regularly with any

24

25





1

2

of the other cardiologists assigned to those wards?

3

4

A. Only as need arose and it generally was when they were on service.

5

6

Q. What would be the general purpose of your frequent meetings with Dr. Rowe?

7

8

9

10

A. It would be generally to talk about my concerns around care for children and families. Any particular concerns I had around functioning in general within the department, and my relationship with the department.

11

12

13

14

Q. Did you in a practical sense, Ms. Browne, function at any time during those nine months as a spokesperson for the other members of the nursing staff assigned to Wards 4A/4B?

15

16

17

18

19

A. I would say, no.

20

21

22

23

24

25

Q. Would you turn now if you would then to the general policies which are set out in the Manual concerning the administration of medications. I will ask you to turn first if you would to Section 14.13. Do you have that, Ms. Browne?

A. Yes.

Q. The provisions read:

"Registered Nurses may administer medications.

A Registered Nurse may give





1

2

"medications for another staff member.

3

Parents and Registered Nursing

4

Assistants may also administer oral

5

medications."

6

Do you see that?

7

A. Yes..

8

Q. Would I be - I am sorry, perhaps

9

we should as well at the same time look at the

10

provisions in 14.14 which deal with the administration

11

of oral medications. I am interested particularly

in Section 1, which reads:

12

"All oral medications must be poured

13

by a qualified nurse."

14

Again we see the phrase that we looked

15

at a few moments ago. Am I interpreting that

16

provision correctly, Ms. Browne, if I conclude that

17

a registered nursing assistant was authorized by the

18

terms of this Manual to pour and deliver oral medi-

cations to patients?

19

A. By definition that is the way

20

it reads.

21

Q. In practice?

22

A. In practice the RNA is not

allowed to do medications.

23

Q. You say the RNA was not allowed -

24

25





1

2

I am sorry.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

THE COMMISSIONER: Well I am getting  
a little lost with respect, I don't understand the  
term. "Registered Nurses may administer medication",  
you must be a registered nurse to administer any kind  
of medication?

THE WITNESS: Yes.

- - - -







H/BN/ak

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

THE COMMISSIONER: And is that not  
contrary to all oral medications, must be poured by --  
oh no, I see. I understand now. A qualified nurse  
includes an R.N.A.?

THE WITNESS: That is right, by  
definition.

MS. CRONK: Q. If I have understood  
Ms. Browne correctly, sir, she has agreed that that,  
by virtue of the definition, would mean that according  
to the Nursing Policy Manual, Registered Nursing  
Assistants would in fact prepare oral medications but  
I thought she had started to say that in practice  
that was not the case; do I have that correctly?

A. Yes.

THE COMMISSIONER: What does the  
word "pour" mean? That does not mean poured into  
the patient, I take it?

THE WITNESS: No, it would be to  
pour it from the bottle into a cup to measure.

THE COMMISSIONER: Oh, prepare.

THE WITNESS: Prepare the medication.

MS. CRONK: Q. I took that to mean  
simply the preparation of medications; do I have that  
correctly, Ms. Brown?

A. That is right.





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

H2 Q. When you said, Ms. Browne, that in practice R.N.A.s did not pour or prepare oral medications, did that remark include or extend to Wards 4A/4B?

A. Yes.

Q. Would I be correct, with reference to Section 14.13 however, Ms. Browne, that a registered nurse could in fact administer medications that had been prepared by another staff member, for example, another registered nurse? I am referring to Section 14.13, Sub 2?

A. The way it reads, it says that.

Q. Well, in practice, again, specific to Wards 4A/4B, to the best of your knowledge, was it acceptable practice for a registered nurse to administer medications of any form that had been prepared by another staff member?

A. No.

Q. What were the practical guidelines that applied on those two wards in that sense?

A. That you poured and gave the medication. If you prepared it, you gave it. If you were going to give medication for another nurse or assume that responsibility, then you prepared the medication.





H3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. If a medication had been prepared by a physician on the ward, Ms. Browne, again, according to the practice on Wards 4A/4B, would there be instances when that medication might be administered by a nurse as opposed to the physician who had prepared it?

A. No.

Q. Once again, if a physician prepared a medication, was it considered to be the responsibility then, of the physician to administer it?

A. Yes.

Q. Would you turn, as well, to Section 14.16 of the manual. Well, perhaps I should ask you, as well, to the best of your knowledge, did physicians involve themselves, in the normal course, in the preparation of medications on Wards 4A/4B at all?

A. No.

Q. And that is the normal course?

A. Yes.

Q. That was the duty and responsibility of the registered nurses on the floor?

A. That is correct.

THE COMMISSIONER: Just a minute, I am getting lost again. Did I understand you to say that the normal practice was that if a nurse was







H4

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

to administer the medicine, she would prepare it herself; is that right?

THE WITNESS: That is correct, yes.

THE COMMISSIONER: But sometimes, I take it, the nurse would prepare it and the physician would administer it; is that correct?

THE WITNESS: No.

MS. CRONK: That was the next question, Mr. Commissioner. I had not yet come to it.

THE COMMISSIONER: Sorry.

MS. CRONK: No, that is perfectly fine, sir.

Q. The question I put, Ms. Browne, was the scenario whereby a physician prepared a medication and a nurse administered it, and she has told us that that would not happen in the normal course.

A. Yes.

Q. For two reasons, I take it. You correct me if I am wrong, Ms. Browne, first, because of the rule that the person who prepares the medication should administer it, and secondly, because physicians did not, in the normal course, involve themselves in the actual preparation of





1

2

medications on those two wards?

3

A. Correct.

4

Q. And then the reverse of that

5

which the Commissioner has just put to you is whether

6

or not in certain circumstances physicians would

7

administer medications that were prepared for the

8

physician by a nurse on the ward?

9

A. Not in normal circumstances,

10

but certainly in an emergency situation, that did  
happen.

11

Q. Indeed, in an emergency

12

situation, and I will come back in more detail later

13

to resuscitation procedures and arrest situations,

14

but generally speaking in an emergency situation,

15

if a physician required a particular medication or

16

drug for administration to a patient, would not he

17

or she request a nurse to prepare or deliver that

18

medication to him so that it could be administered?

19

A. Yes.

20

Q. That was the normal rule, was  
it not?

21

A. Yes.

22

Q. Thank you. Could I ask you

23

to look at, then, Section 14.16 of the manual, which

24

specifically relates to the administration of digoxin,

25





H6

1

2

and I would like to read this provision in full.

3

The first paragraph, Ms. Browne, indicates:

4

"1. A qualified nurse giving a dose  
of Digoxin to a patient must have the  
calculations and the amount checked  
with a second nurse. One of these  
nurses must be registered."

5

6

7

8

9

10

11

12

13

14

15

Now, stopping there for a moment, having regard to  
the definition of "qualified nurse" which we looked  
at a few minutes ago, am I correctly interpreting  
this section if I conclude that a registered nursing  
assistant was authorized by the Department of  
Nursing to administer a dose of digoxin so long as  
the provisions of this sub-paragraph were compiled  
with?

16

A. As it reads, yes.

17

18

19

20

Q. Once again, I ask you, in  
practice on Wards 4A/4B, were registered nursing  
assistants permitted, to the best of your knowledge,  
to administer doses of digoxin in any form to a  
patient?

21

A. No.

22

23

Q. Did that extend, as well, to  
oral forms of the medication, Ms. Browne?

24

25

A. Yes.





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

H7 Q. Would I be correct, then, in summarizing the situation in this fashion: although the manual authorizes registered nursing assistants to prepare oral medications, and appears on the basis of the language that appears to authorized registered nursing assistants to actually administer digoxin, in practice they neither prepared medications nor did they give digoxin in any form?

A. That is correct.

Q. That was the general rule on the wards?

A. Yes.

Q. If we look, then, at paragraph 14.16, sub-paragraph 2 of that section, it reads:

"2. If the apical rate is less than 60, the dose of Digoxin should be held until the doctor is notified."

Can you briefly explain for us what you understand that to mean?

A. Part of the registered nurse's responsibility in preparing and giving digoxin is to check the patient's apical heart rate before administering, before giving the medication. If indeed the heart rate was less than 60, the digoxin would not be given.







1

2

H9

H8

Q. It would simply be held until

3

further consultation with a responsible physician?

4

A. Exactly.

5

Q. If we look again, then, at

6

the provisions set out in paragraph 1, you have

7

told us that in practice that did not apply to

8

registered nursing assistants, would I be correct

9

in concluding that any registered nurse on Wards 4A

10

could administer a dose of digoxin to a patient so

11

long as the calculations involved in preparing the

12

dose and the amount to be administered had been

checked with the second nurse?

13

A. That is correct.

14

Q. And in practice, was that the

case?

15

A. Yes, it was.

16

Q. Was the nurse who was required

17

to check the calculations and the amount of the dose

18

required to be a registered nurse or could that be

19

a registered nursing assistant?

20

A. That would have to be a

21

registered nurse as well.

22

Q. Do I have it, then, correctly

23

that if a registered nurse on Wards 4A/4B was intended

24

to give or had been requested to give a dose of

25





H10

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

are in here, how did the nurses get to know about them? You say in practice that it is always a registered nurse, but some innocent coming in for the first time reading the rules may not appreciate that.

Do people just sort of divine it in some way or did you tell them, or what happened?

THE WITNESS: That was communicated as part of an orientation to the ward before you would assume responsibility for medications.

THE COMMISSIONER: Just in my innocence, I would have thought it would be easier just to take that they are all ---

MR. PERCIVAL: Mr. Commissioner, it is very difficult to hear you, sir.

THE COMMISSIONER: It is probably just as well. It would seem to me to be reasonable to put in a new rule if you were going to ---

THE WITNESS: Yes.

THE COMMISSIONER: But you did not do that?

THE WITNESS: No.

THE COMMISSIONER: I am not saying that there is anything wrong with -- if you can manage to get it through to everybody, but if you do





H11

1

2

not get through to everybody, how do they know?

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

THE WITNESS: Well, because of it being a pediatric unit and a specialized unit, there was a fair bit of time and energy spent in orientating staff to medications and being sure that they were well informed about protocol.

THE COMMISSIONER: This is the major place where digoxin would be administered, would it not be, in the Cardiology Ward?

THE WITNESS: Yes.

THE COMMISSIONER: I know it would be administered in others, and would this just apply to Wards 4A and 4B or would the written instructions apply elsewhere than 4A and 4B? For instance, in the Neonatal Ward or whatever the ward, Ward 7, what happens there? Would this apply or would the same thing apply, that even there you would have ---

THE WITNESS: The same policy applies, and I expect was interpreted in the same way.

THE COMMISSIONER: Well, you could not conceivably interpret it the way you have said it, because one of these nurses must be registered and you say two of them must be.

THE WITNESS: Yes.

THE COMMISSIONER: Yes, all right.

Thank you.







1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MS. CRONK: Q. Well, to be clear, Ms. Browne, a number of points. First of all, I take it that the manual we are looking at was not a manual specific to Wards 4A/4B; it was the overall manual for the entire nursing staff in the Hospital, is that correct?

A. Yes.

Q. But it did apply equally to Wards 4A/4B?

A. Yes.

Q. And secondly, and perhaps most importantly, Ms. Browne, there is on my reading of the section nothing in Section 14.16 which confines that policy to oral doses of digoxin. It is, however, my understanding, and I suggest to you, there was a different policy which applied to intravenous medications and administrations of digoxin; do I have that correctly?

A. That is correct.

Q. And I will come in a moment to the policy that applied to the administration of IV preparations, but would I be correct then, and fair in suggesting that the policy reflected by Section 14.16 to the best of your knowledge, applied then only to oral doses of digoxin?





H13

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

A. Yes.

Q. Did it apply, as well, to digoxin in tablet form as well as to digoxin in elixir form?

A. Yes.

Q. Was there anything specific to Wards 4A/4B by way of written guidelines or a written clarification that was printed to further detail what was intended by the provisions of the manual with respect to the administration of digoxin insofar as you know?

A. There may have been by the teaching team later, but I cannot speak to that.

Q. Thank you. Would you turn now then, if you would, please, to Section 18.01 of the manual. We see that Section 18.01, subparagraph 1, Ms. Browne, indicates that:

"1. A registered nurse may add medications to a vacolitre or I.V. tubing above the drip bulb or the pedatrol."

Now, before I ask you the general meaning of that policy, can you explain to us what a vacolitre is, if you would?

A. It would be either a bottle or a bag of intravenous solution.





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. It is my understanding that the term actually encompasses both the glass bottle, which is attached to the IV apparatus, and the plastic bag actually containing the IV solution; is that correct?

A. Yes.

Q. We have heard something in these proceedings about a buretrol that forms part of the IV apparatus. Is that the same, in your judgment, as a pedatrol?

A. By function, yes.

Q. Well then, there is a distinction which you have not yet outlined for us. What is the distinction?

A. The pedatrol was a plastic container with five sections so you could fill it with 50 cc of fluid. It was so on a small patient.

THE COMMISSIONER: Excuse me a moment, could we not have our exhibit out so we could see it?

MS. CRONK: Yes, we can, sir. I believe it is Exhibit 227, Mr. Registrar.

Q. It would perhaps be easier if you could actually point it out to us.

A. Okay.





1

2

H15

3

MS. CRONK: I do not think we have  
a vacolitre, sir.

4

5

6

7

8

Q. Ms. Browne, before I embarrass  
myself totally with this, I would ask you to take  
the apparatus, if you would, and explain to us first  
what the vacolitre is and then what you are describing as  
the pedatrol?

9

A. This is the vacolitre, which  
is ---

10

11

THE COMMISSIONER: The vacolitre is  
the bag at the top, I take it?

12

THE WITNESS: Yes.

13

14

MS. CRONK: Q. Perhaps if you could  
just stand up, Ms. Browne, it would make it easier.

15

A. And this one holds 250 cc.  
They did come in different sizes.

16

17

18

Q. Now, if there was a bottle,  
Ms. Browne, attached as well to the IV apparatus,  
would that be in addition to the IV solution bag?

19

A. No.

20

21

22

-----

23

24

25







I  
BB/cr

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. That would be a substitution  
for it?

A. Yes.

Q. So, whichever it was, it  
was properly called a vacolitre.

THE COMMISSIONER: That is at the  
top of the whole apparatus, is that right?

THE WITNESS: Yes.

THE COMMISSIONER: That is initially  
whatever is going into the baby goes, is that right?

THE WITNESS: Yes.

MS. CRONK: Q. And what then are  
you referring to as the, or is referred to as the  
pedatrol?

THE COMMISSIONER: Is that called  
the vacolitre, did you say?

THE WITNESS: This part if the  
vacolitre.

THE COMMISSIONER: Yes. That is  
not what we called it before. What did we call  
it before?

MS. CRONK: I called it an IV bag  
before, so, if there is another word for it it  
escapes me.

THE COMMISSIONER: Well, is it





1

2

popularly known as a vacolitre?

3

4

THE WITNESS: No, I would call it  
an IV bag.

5

6

MS. CRONK: Well, there you are,  
there you are.

7

8

THE COMMISSIONER: All right. Very  
well, IV bag at the top, yes, all right.

9

10

THE WITNESS: Can I refer to it,  
this is a buretrol rather than a pedatrol which  
serves the same function.

11

Q. All right.

12

13

14

15

A. And this one goes up to 150  
cc's. So that if you wanted to run in a set  
amount over an hour you would fill the buretrol  
with that amount, so, you would know that the child  
wouldn't get any more than that.

16

17

18

Q. All right. And how then is  
the pedatrol different from what we see there as  
a buretrol?

19

A. It only holds 50 cc's.

20

21

Q. It is simply smaller in  
dimension and size?

22

23

24

25

A. Yes.

Q. Is it located at approximately  
the same place in the IV line?





1

2

A. It's in the same place.

3

There was an older version.

4

Q. I see.

5

A. It wasn't as accurate in  
its measurement.

6

7

8

9

Q. I see. And as well there is  
reference in the section that we were looking at  
to the drip bulb. Can you tell us what that is and  
where it is?

10

11

A. It is right here, or drip  
chamber.

12

Q. What is the purpose of that?

13

A. It controls your flow so you  
have small drops coming from the buretrol.

14

15

Q. And how does it control the  
flow?

16

17

18

A. Well, it is controlled by  
this valve and you then could observe the number  
of drops per minute coming from the buretrol.

19

20

21

22

23

24

25

Q. Do I have it then, Miss  
Browne, that if you want to control the speed of  
flow of the drug from the buretrol through the  
drip bulb down into the IV line you simply manipulate  
the control, the blue control lower on the line  
that you are pointing out now?







1

4

2

A. That's right.

3

Q. Can you manipulate it in

4

such a way that there is a greater speed of the

5

drug in a flow sense through the line or a slower

6

speed?

7

A. Yes.

8

Q. So you can accelerate it or

decrease it?

9

A. Yes.

10

Q. And what are the purposes,

11

if you look to the top of the IV apparatus, and

12

we may have had this before from another witness,

13

sir, in a different way, but what are the purposes

14

of the various units which appear below the IV

bag and above the buretrol.

15

A. If you wanted to add

16

medication to the IV bag, if you will, it would

17

be injected through there.

18

Q. You are pointing to a small

19

tube of entry at the bottom of the IV bag?

20

A. Yes. If you wanted to

21

add medication to go in over an hour, say, in the

22

fluid that let down into the buretrol you would

add it through here.

23

Q. And you are pointing to a

24

25





1

5

2

point of entry at the top of the buretrol?

3

A. Yes.

4

Q. All right. And is there some

5

intermediary unit in between those two ports of  
entry?

6

A. No. .

7

Q. What is this?

8

A. This controls the flow from

9

the bag into the buretrol.

10

Q. All right. And towards the

11

bottom of the IV apparatus, Ms. Browne, below

12

the flow control mechanism that you described

13

there are we have heard before a number of ports

14

of entry or various locations in which drugs can

15

be administered and applied to enter the IV line.

16

Do I have that correct so far?

17

A. That is correct.

18

Q. And if you could just continue

19

to hold the IV apparatus for a moment and I will

return you to the policy statement in Section 18.01

of the Manual it indicates that:

20

"A registered nurse may add

21

medications to a vacolitre ...."

22

and I take that to be obviously the IV bag in

23

this particular form of apparatus?

24

25





Browne, dr.ex.  
(Cronk)

1

2

A. Yes.

3

4

Q. And to add a medication to  
that you would use the port of entry right at the  
bottom of the bag?

5

6

A. Yes.

7

8

9

Q. Or alternatively a registered  
nurse could add a medication to the IV tubing  
above the drip bulb or above the pedatrol or the  
buretrol?

10

A. Yes.

11

12

13

14

15

16

Q. All right. Do I have it  
correctly then that according to this policy state-  
ment the only locations on the IV apparatus where  
a registered nurse could in an authorized fashion  
add a medication would be above that drip bulb  
that appears immediately below the buretrol or  
above the buretrol itself?

17

A. Yes.

18

19

Q. And as well to the IV bag  
or the IV glass bottle containing the IV solution?

20

A. Yes.

21

Q. To the best of your knowledge,  
could a registered nurse on Wards ---

22

23

24

25

MS. KITELY: Mr. Commissioner, the  
witness has been holding the bag for a while. If





1

2

my friend is going to continue ---

3

4

THE WITNESS: That's all right, I  
have done this before.

5

6

MS. KITELY: I just thought that we  
could ---

7

8

THE WITNESS: I could hang it up over  
there.

9

10

MS. CRONK: If anything is going to  
happen to this bag it is not going to be while I  
am on my feet, Ms. Browne.

11

12

MR. HUNT: Could I ask one question,  
Mr. Commissioner.

13

THE COMMISSIONER: Yes.

14

15

16

17

18

MR. HUNT: That bag or that apparatus  
was introduced some time ago by Dr. Spielberg I  
believe and I don't think at the time there was  
any indication as to whether that was the apparatus  
that was being used during the period that we are  
concerned with.

19

20

21

22

23

24

25

Now, the witness has referred to an  
older version of the apparatus and I wonder if my  
friend would clarify it at this point whether what  
we have here is the actual apparatus that was being  
used during the period of time or whether it was  
some other version that we don't have.







1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MS. CRONK: I am uncertain as to the answer to that, Mr. Commissioner. My recollection like Mr. Hunt is ---

A. I could tell you that that is the equipment at that time. The term pedatrol and my knowledge of it dates both of us.

Q. All right. So, to the best of your knowledge, that is the form that was in use on Wards 4A/B during that 9 month period?

A. Yes.

Q. Thank you. I was about to ask you then, Ms. Browne, apart from the authorized sites at which a registered nurse could add a medication to the IV line, and I reflected in Section 18.01 of the manual, to the best of your knowledge, could a registered nurse on Wards 4A or 4B in an authorized sense administer an IV medication at any other site on the IV line?

A. No.

THE COMMISSIONER: It's strange though that it doesn't say so, but perhaps it does say so on some of these other ones. They say what the registered nurse may do and may not do and it doesn't seem to cover that part between the, I guess it is the buretrol and the patient, that





1

2

tubing.

3

4

This push method that they are talking about, would that be if you do administer in that area, is that called a push method?

5

6

THE WITNESS: If you administer below.

7

8

THE COMMISSIONER: That's called the push method.

9

10

THE WITNESS: Below the drip chamber.

11

12

THE COMMISSIONER: If anything you don't really actually push it you just administer it in there and if that's so that is called the push method?

13

14

THE WITNESS: Yes.

15

16

MS. CRONK: I am sorry, now, sir, now as is easily done I am a little bit confused. Could we perhaps clarify that because I am going to come in a moment to the provisions that apply to the push method.

17

18

19

THE COMMISSIONER: Yes.

20

21

22

23

24

25

MS. CRONK: I had understood and perhaps wrongly Ms. Browne from prior evidence that the way in which the drug was administered intravenously could in some circumstances actually accurately be described as a push because physically





1

2

the medication was pushed through the syringe

3

either into the patient or into the IV line. Do

4

I have that much correctly?

5

A. Yes.

6

Q. But in other situations you

7

could administer a drug from a syringe into the

8

IV line without doing it by pushing the drug in

9

the same way through the syringe into the IV line.

10

Is that a misunderstanding on my part?

A. I don't think so.

11

Q. All right. Well then, to

12

put the Commissioner's question then again. If

13

you administer a drug anywhere on the IV line below

14

the drip bulb is that necessarily called administration  
by IV push?

15

A. No.

16

Q. All right.

17

THE COMMISSIONER: Well then we are

18

in real trouble if that is so because 18.01 and

19

18.02 still leaves a gap, the administration

20

without the push method in the tubing below the

21

buretrol, can a nurse or can she not?

22

THE WITNESS: She cannot.

23

THE COMMISSIONER: Well, that's what

24

you say but, you see, we are trained to read the

25







1

2

regulations.

3

MS. CRONK: Well, sir, if I can  
perhaps assist.

4

5

THE COMMISSIONER: All right.

6

11

7

MS. CRONK: Q. Could we look then,  
and may we just clarify this that on the basis of  
Section 1801, in addition to adding medication to  
the buretrol a nurse could add a medication above  
the drip bulb?

8

9

A. Yes.

10

11

Q. All right. Does that necessarily  
mean to the buretrol. Is there any other  
physical place on that line that you can add a  
medication above the drip bulb that is not into  
the buretrol?

12

13

14

A. Into the IV bag.

15

16

Q. I am sorry, right.

17

18

MR. HUNT: If we can just hang it  
up, I am getting confused.

19

THE COMMISSIONER: I think we are  
going to have to do something with it because I'm --

20

21

MS. CRONK: You are insisting that  
I pick that up again.

22

23

THE COMMISSIONER: Well, we can put  
it up on the blackboard.

24

25





12

1

2

MR. PERCIVAL: Mr. Elliott can hold

3

it up.

4

MS. CRONK: As I understand it, the

5

drip bulb is this approximately 2½ inch apparatus

6

below the buretrol. Do I have that correctly?

7

A. Yes.

8

Q. So that according to Section

9

18.01 just to do it one more time, a nurse could

10

administer a medication anywhere above this drip

11

bulb and that would necessarily mean into the

12

buretrol or into the IV bag or the IV glass bottle,

13

if there were one on the apparatus?

14

A. Yes.

15

Q. All right. And that access

16

would be gained by using the port of entry at the

17

bottom of the IV bag or at the top of the buretrol?

18

A. That is correct.

19

Q. Thank you. Then if we turn

20

Ms. Browne to the policy set out in 18.02 of the

21

manual we see that it specifically addresses the

22

question of medications administered by the push

23

method intravenously and paragraph 1 indicates

24

that:

25

"All I.V. medications that are to be

given by the 'push' method must be





1

2

"given by the doctor."

3

A. Yes.

4

Q. You started a few moments

5

ago I thought you said that you could administer

6

a drug. By you, I don't mean a registered nurse,

7

but a person could administer a drug on an IV

8

line below the buretrol other than by the push

9

method. Do I have that correctly?

13

A. Yes.

10

Q. All right. In practice, Ms.

11

Browne, and to the best of your knowledge, were

12

registered nurses or registered nursing assistants

13

on Wards 4A/4B allowed or authorized to administer

14

medications to an IV line anywhere below the

15

buretrol?

A. No.

16

Q. All right.

17

MR. SCOTT: Can we have a definition

18

of push method, I think that is where the difficulty

19

is.

20

MS. CRONK: Can you help my friend?

21

MR. PERCIVAL: Mr. Commissioner, one

22

of the things that escapes me, and my rudimentary

23

knowledge of engineering gives me some measure of

24

concern here because does it go in by gravity or

25





1  
2 does it go in as a result of the force of the plunger  
3 or perhaps we could ask for a clarification by the  
4 witness.

5 MR. SCOTT: Come on, Ms. Cronk.

6 MS. CRONK: I think that is the  
7 definition.

8 Q. Could you define for us  
9 what you understand the push method to be?

10 A. The push method is by  
11 physically pushing it in through a syringe.

12 Q. Other than doing it that way  
13 how could one physically add medication to the  
14 IV line below the buretrol?

15 A. It could be added into the  
16 tubing, which it would then be diluted in the  
17 tubing and wouldn't be administered with as much  
18 force or with the same speed.

19 Q. Would you use a syringe to  
20 accomplish adding the medication that way too?

21 A. Yes.

22 THE COMMISSIONER: Does that happen  
23 quite often that one does it without the - I am  
24 not talking about improper conduct, but does anyone,  
25 physician or anyone else, ever add to that tubing  
without using the push method?







1

2

A. Not that I can think of.

3

Q. Well, that may be the answer

4

that nobody contemplated this, but there is nowhere,

5

is there, is the nurse prohibited, at least maybe

6

I am wrong, but nowhere is the nurse prohibited from

7

adding to the tubing so long as she doesn't use

8

the push method because 18.02 seems to talk about

9

the push method and 18.01 allows her to add to the

buretrol but not to the blood.

10

MR. SCOTT: Isn't it practically

11

irrelevant because if almost all of the drug

12

administered in the tubing are administered through

13

the push method, and those can be administered by

a doctor, then what are we concerned about?

14

THE COMMISSIONER: Maybe you are

15

right, maybe you are right, but I would have thought

16

that the simple answer would be, instead of saying

17

a registered nurse may add medication to so and

18

so that they say may only add or something, may add

19

only to this thing and then it would make a simple

mind like mine understand it.

20

MR. SCOTT: The Rules Committee of the

21

Supreme Court of Ontario would spend about two

22

years drafting this particular rule and then still

23

wouldn't have it out and, of course, the Hospital

24

25





Browne, dr.ex.  
(Cronk)

1  
2 has to run on anyway, the courts perhaps don't. But  
3 as a practical matter isn't it clear that, and  
4 I think I'm not saying anything different than Miss  
5 Cronk, that 18.02(1) deals with what a doctor may  
6 do, the alternative non push, what I might call  
7 the drip method, is administered under 18.01.

16

8 THE COMMISSIONER: All right. What  
9 I am really worried about is, perhaps you figured  
10 it out, apparently, you tell me that it is improper  
11 for a nurse, a registered nurse to add anything  
12 below the buretrol.

13 THE WITNESS: That's right.

14 THE COMMISSIONER: It doesn't say  
15 so but you tell me it is improper?

16 THE WITNESS: Yes.

17 THE COMMISSIONER: Whether she uses  
18 a push method or anything else?

19 THE WITNESS: Yes.

20 THE COMMISSIONER: And I take it if  
21 you saw a nurse who was adding something to the  
22 line below the buretrol you would suspect something  
23 was wrong?

24 THE WITNESS: Yes.

25 THE COMMISSIONER: And if you were to  
chart her, if she went to those regulations and she





1  
17 2 had a good lawyer like Mr. Scott he would say, well,  
3 there is nothing wrong with it, she wasn't using  
4 the push method so, you can't do anything to her.

5 MR. SCOTT: Well, he would plead  
6 guilty.

7 MS. CRONK: I think that is what I  
8 said.

9 MR. SCOTT: He would plead guilty  
10 because the position is that you can't administer  
11 in a practical sense.

12 THE COMMISSIONER: But it doesn't  
13 say that, that's all I am saying, it doesn't say  
14 that.

15  
16  
17 - - - -  
18  
19  
20  
21  
22  
23  
24  
25







J/DM/ak

1

2

3

MR. SCOTT: No, the push method,  
IV injection.

4

5

THE COMMISSIONER: That is right if  
she pushed, but if she didn't push.

6

7

MR. SCOTT: You were dealing at  
18.02 with IV injections.

8

THE COMMISSIONER: Yes.

9

10

MR. SCOTT: And the push method as  
I understand the witness to say, the only practical  
method of introducing it below the drip ---

11

12

13

14

15

16

THE COMMISSIONER: All I am saying  
is under these regulations if nobody saw her push  
there is no charge, there is no conviction possible.  
If it comes, I don't know what will happen in  
Divisional Court, but if it comes to the Court of  
Appeal I could tell you what is going to happen, she  
will get off.

17

18

19

20

MR. SCOTT: I will have to redo  
my advice and tell her that she is probably Guilty  
but to plead Not Guilty and see if we can get the  
case on before you.

21

22

MS. CRONK: Can I, necessarily, sir,  
perhaps the confuse the matter a little further?

23

24

25

Q. Could you look if you would,  
Ms. Browne, at paragraph 2 of 18.02 which speaks on





J2

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

my reading to a situation where a certified nurse in a particular location in a hospital may in fact administer certain kinds of drugs by IV push, am I interpreting that correctly?

A. Yes.

Q. So that would appear to be, and we will examine the specifics for that in a moment, but that would appear to be an exception to the general rule that medications administered by the IV push method must in all circumstances be administered by physicians?

A. Yes.

Q. To examine the exception to the rule if we could please turn to Section 16.06 of the Manual, the Special Procedures section.

Number one, Ms. Browne sets out I suggest the general policy and it provides:

"Specially trained and certified registered nurses working in the areas designated may administer IV medications directly into the IV site or below the drop chamber as ordered by the physician."

And then sub 2 reads there are certain exceptions, and the first drug named is





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

J3

"digoxin" followed by several others:

"...must be administered by the physician  
when ordered by the intravenous route."

To put it very simply would I be correct in suggesting  
that although there is an exception to the rule that  
only physicians may administer drugs by IV push,  
the exception does not apply to the drug digoxin, and  
if that is going to be administered by the IV push  
method it must be administered by the physician who  
orders it, do I have that correctly?

A. Yes.

Q. And in any event as I understand  
the policy, Ms. Browne, it is only in certain areas  
of the Hospital that certified nurses can administer  
drugs by IV push, those are called "designated areas"  
and they are detailed in paragraph 3 of Section 16.06  
and they do not include Wards 4A/4B or their  
predecessor Ward 5A, do I have that correctly?

A. Correct.

Q. There is however mention made,  
and this is relevant perhaps to one of the children  
whose death is being considered by this Commission,  
to the administration in the Intensive Care Unit of  
medications by the IV push method, and that is set  
out in paragraph 3 of Section 16.06 and the indication  
is:





J4

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

"Special criteria must be observed in the Intensive Care Unit when administering digoxin by IV push."

Do you see that?

A. Yes.

Q. I know that at one stage of your career with the Hospital for Sick Children you worked directly in the Intensive Care Unit, and you have told us that as a clinical nurse specialist your area of responsibility included cardiac patients in the Intensive Care Unit. Are you in a position to outline for us the criteria which applied in the Intensive Care Unit in a situation where a nurse was intending to administer digoxin by intravenous push?

A. I would hesitate to do that for the time in question.

Q. We will have to get that then perhaps from another witness.

So as the matter stands then, with respect to Wards 4A/4B during the nine-month period with which we are concerned, as I understand it, no drug could be administered by a registered nurse, or a registered nursing assistant by the IV push method and more particularly digoxin could not?

A. Correct.







J5

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. The Manual refers in a number of places, Ms. Browne, to drugs referred to as "investigational drugs"; for example I note that is referred to in Section 16.06 that we have just looked at, in paragraph 2. Very briefly could you outline for us what you understand to be an investigational drug?

A. It is a drug that is under study, so it is not a drug that could be prescribed. It would be covered by a study protocol and the parents would be asked to sign a consent for the drug to be used on their child, so they would be well informed so it would not be a routine form of medication.

Q. I take it digoxin is not considered to be an investigational drug?

A.. No.

Q. Can we turn now then, Ms. Browne, generally to those sections of the Manual dealing with the various duties and responsibilities both of registered nurses and more particularly of registered nursing assistants.

Dealing first with the provisions of Section 16.01, and I don't propose to review these in detail. But as I understand it, Ms. Browne, and





J6

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

I ask you to confirm whether my understanding is correct or incorrect, there were various special procedures which registered nurses could perform in the Hospital so long as they were specifically authorized in this Manual, do I have that correctly?

A. Yes.

Q. And the special procedures in some instances could only be performed by registered nurses in specific areas of the Hospital, but in other cases could be performed throughout the Hospital?

A. That is right.

Q. Am I further correct that with respect to those special procedures a nurse had to be specially qualified and hold a special certificate in order to undertake a procedure that was considered not in the normal course of the duties of a registered nurse?

A. That is correct.

Q. If we turn for example to the section, and I should add that those provisions as I understand it are set out in Section 16.01 of the Manual, is that correct?

A. Yes.

Q. I ask you to turn by way of





J7

1

2

example if you would to Section 16.13.

3

MR. SCOTT: What page?

4

MS. CRONK: Section 16.13, Mr. Scott.

5

Q. This provision deals with

6

"nasogastric tubes", Ms. Browne, and it states:

7

"Registered nurses may insert nasogastric

8

tubes for feeding gastric suction, or

9

gastric analysis on conscious patients.

10

Specially trained and certified nurses

11

may insert nasogastric tubes on

12

unconscious patients."

13

The next paragraph indicates:

14

"The designated area was throughout the  
Hospital."

15

Is that an example, Ms. Browne of

16

a special procedure which a registered nurse was

17

authorized by the Manual to perform throughout the  
entire Hospital?

18

A. Yes.

19

Q. And that applied to the

20

insertion of nasogastric tubes for specified purposes

21

so long as it was being applied to a patient who

22

was conscious?

23

A. Yes

24

Q. And by way of further example,

25







J8 1  
2 if I could ask you to turn to Section 17.01, these  
3 provisions deal with intravenous therapy. I draw  
4 your attention first to paragraph 1 which provides:

5 "An intravenous infusion must be started  
6 either by a doctor, a member of the IV  
7 team or a certified nurse in a desig-  
8 nated area."

9 Now, stopping there for just a moment  
10 if I may. Can we agree again that based on the  
11 definition of certified nurse in the first instance  
12 that policy would appear to apply to registered  
nursing assistants?

13 THE COMMISSIONER: Is that qualified?

14 THE WITNESS: It was qualified.

15 MS. CRONK: It was qualified and  
16 certified, sir, if you recall.

17 THE COMMISSIONER: I got lost again.

18 THE WITNESS: By definition.

19 THE COMMISSIONER: What is a  
certified nurse?

20 MS. CRONK: It is a nurse who has  
21 received special training in order to become competent  
22 in a special procedure, and I am reading now, sir,  
23 from the definition section, and she is the holder of  
24 a special procedure certificate. Ms. Browne earlier  
25





1  
2 told us that the definition itself does not appear to  
3 exclude registered nursing assistants, have I stated  
4 that correctly?

5 THE WITNESS: Yes.

6 THE COMMISSIONER: All right.

7 MS. CRONK: Q. So do I have it  
8 then without more, and we will proceed to the rest  
9 of the rule in a moment, that on the face of that  
10 paragraph a registered nursing assistant if she held  
the certificate could in fact start IV's?

11 A. As it was stated, yes.

12 Q. I ask you to consider if you  
13 would, paragraph 4 under Section 17.01 which reads:

14 "Registered nursing assistants may care  
15 for patients on intravenous therapy.

16 However, a registered nurse must assume  
17 responsibility for the IV."

18 I suspect you see immediately what  
19 my problem is, Ms. Browne. That section appears,  
20 suggests to me that indeed registered nursing  
21 assistants were not authorized to start IV therapy  
22 but rather could care for patients on it so long  
23 as a registered nurse had assumed responsibility  
generally for the IV?

24 A. That is correct.  
25









1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. There appears then to be a conflict perhaps without stating it too highly between those two provisions?

A. Yes.

Q. In practice on Wards 4A/4B were registered nursing assistants permitted or authorized to start IV therapy?

A. No.

Q. What was the role that registered nursing assistants on those wards could play with respect to IV therapy or IV apparatus as it applied to patients?

A. She could observe the intravenous and the site where the intravenous goes into the patient but she had no responsibility for what was actually done to the IV.

Q. Could she start it or discontinue it or in any way adjust the flow of the IV medication?

A. No.

Q. Was she then to have any direct contact in other than an observational sense with the IV apparatus at all?

A. No.

Q. And if we look at paragraph 3 of Section - again, 17.01 we see that:







1

2

"A qualified nurse..."

3

Again the same trouble in definition:

4

"...is authorized to change vacolitre."

5

6

7

8

9

Again that suggests by way of definition to me that a registered nursing assistant could change an IV solution bag or an IV solution glass bottle; am I at least interpreting the policy correctly?

10

A. By definition, yes.

11

12

13

Q. And in practice once again could a registered nursing assistant in any way deal with the IV solution bag, or the IV solution bottle on an IV apparatus?

14

A. No.

15

16

17

18

19

Q. More specifically, could we examine what the Manual does say in an affirmative sense with respect to the role and function of a registered nursing assistant, and I would ask you to turn to Section 28.39 if you would. Do you have that, Ms. Browne?

20

A. Yes, I do.

21

22

Q. The first two sub-paragraphs of 28.39, Ms. Browne appeared to indicate:

23

24

25

"The fundamental role of the registered nursing assistant is to give basic





1  
2 "bedside care to patients."

3 Sub-paragraph 2 reads:

4 "She or he functions as a team member  
5 within the concept of team nursing  
6 and works under the direction and  
7 supervision of a team leader who is  
8 a registered nurse."

9 I think you have told us earlier that  
10 the team leaders on Wards 4A/4B, if I have it  
11 correctly, were all registered nurses, do I have  
12 that correct?

13 A. Yes.

14 Q. Do you agree based on your  
15 familiarity with the operations, that is a bad word  
16 in a medical context; based on your familiarity with  
17 Wards 4A/4B, do you agree that paragraphs 1 and 2  
18 are an accurate description of the role of the  
19 registered nursing assistant as he or she fulfilled it  
20 on those two wards?

21 A. Yes.

22 Q. And if we look at 28.40, I'm  
23 sorry, could I ask you first to look at 28.41 which  
24 is entitled: "Approved General R.N.A. Functions".

25 Am I correct, Ms. Browne, that this  
section is really a rescitation in some detail of





1

2

those activities which were specifically authorized  
to be performed by registered nursing assistants?

3

4

A. Yes.

5

6

Q. And they include for example,  
authority to be involved in the basic care of the  
patient who is on an intravenous apparatus?

7

8

A. Yes.

9

Q. I am sorry.

10

A. Yes.

11

Q. And they include as well the  
authority to conduct cardiopulmonary resuscitation?

12

A. Yes.

13

14

Q. And they include as well  
administration of an oral medication if it has been  
poured by a registered nurse who assumes full  
responsibility for it, do you see that?

15

16

A. Yes.

17

Q. May we stop there for a moment.

18

In light of what you have told us earlier, although  
there is a specific policy authority granted to  
registered nursing assistants to administer oral  
medications as we see in this section, does that  
authority in any way deviate from what you have  
told us was the practice on Wards 4A/4B?

19

20

21

22

23

A. No. Can I qualify that?

24

25







1

2

Q. Of course.

3

A. In that if the child was more

4

comfortable with the registered nursing assistant

5

and would more readily drink medication from the

6

registered nursing assistant, it would be the

7

registered nursing assistant who would give the

8

medication to the child, that didn't relieve the R.N.,

9

the registered nurse of responsibility for seeing

10

that the medication was taken by the child.

11

12

13

-----

14

15

16

17

18

19

20

21

22

23

24

25





1

K/BN/ko

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. I am sorry, well, may I be sure, then, that I understand that. In that situation, depending upon the degree of familiarity of the patient with the registered nursing assistant, the registered nursing assistant could in fact, on occasion, administer medications orally?

A. Yes.

Q. In those situations who would have drawn up the medication?

A. The registered nurse.

Q. Would the registered nurse be required to be present in the room at the time that the registered nursing assistant administered the medication?

A. In actual sense she should be. In practice that was not always the case. If she was --

MR. PERCIVAL: Mr. Commissioner, we are dealing with children over the age of two because then it becomes not really an exception. I gather that what the witness is saying is that insofar as if the child is familiar with the RNA, he would have some difficulty in accepting but if the child is --

THE COMMISSIONER: No, but a baby surely could be familiar with one nurse.

MR. PERCIVAL: It might be. I do not





1  
K 2 2 know whether that applies to 4A and 4B.

3 MS. CRONK: I am grateful to my friend  
4 and let me put the question to Ms. Browne.

5 Q. Does that kind of situation  
6 arise with young infants?

7 A. It would tend not to.

8 Q. Could it arise with a child over  
9 one year of age but less than two years of age?

10 A. Yes.

11 Q. And in those situations, the  
12 registered nursing assistant, if the child was more  
13 comfortable with it, could actually administer the  
14 oral medication?

15 A. Yes. Could I qualify that it  
16 would be the registered nurse's responsibility to be  
17 sure that the medication was given.

18 Q. Yes, I think you in fact  
19 indicated that, although I take it in practice you  
20 have said that in some instances the registered nurse  
21 may or may not be physically in the room at the time  
22 the medication was administered?

23 A. Yes.

24 Q. To the best of your knowledge,  
25 Ms. Browne, did that include the drug digoxin if it  
was to be administered orally to a patient in that





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

K 3

category?

A. No.

Q. Digoxin was then an exception?

A. Yes.

Q. Was that on the basis of some informal or formalized policy on Wards 4A/4B?

A. I would say it was formal in that the registered nurse needed to check the apex before the digoxin was given. So she would check the apex and give the digoxin.

Q. May I put this potential scenario or hypothesis to you. If you had a situation on Wards 4A/4B where a child was to receive an oral dose of digoxin, had developed that kind of relationship with the registered nursing assistant so that the patient appeared to be more comfortable with a registered nursing assistant, a registered nurse drew up and prepared the oral dose of digoxin, checked the apical rate of the patient, in those circumstances, to the best of your knowledge, would a registered nursing assistant be permitted to administer the oral digoxin to the child?

A. No, I think it would still be the registered nurse.

MR. SCOTT: Mr. Commissioner, it is







1  
K 4 2 almost lunch time and I wonder if I could raise some-  
3 thing that is procedural before the break. It will  
4 only take a minute or two.

5 THE COMMISSIONER: Well, whenever it  
6 is a convenient time to break off.

7 MS. CRONK: That is fine, sir, I can  
8 do it now or you can entertain Mr. Scott and I can  
9 continue.

10 MR. SCOTT: Well, I understand that  
11 this witness, like some of the others that we will be  
12 dealing with and some we have dealt with, that the  
13 Police have a "will say" statement, as they are called,  
14 with respect to potential evidence. I wonder if I  
15 could ask Mr. Percival, who happily has joined us  
16 again, if he could produce it?

17 MR. PERCIVAL: Mr. Commissioner, I  
18 have made what is called an anticipated evidence of  
19 Carol Browne, and I understand that certainly Ms.  
20 Browne has had the document and it is in a typed form.  
21 I am content to give it to my friends providing the  
22 witness agrees and Ms. Kitley agrees. I think that  
23 is the hang up, as I see it, at the present time.

24 THE COMMISSIONER: Well, maybe it is  
25 not a hang up. What do you say?

MS. KITELY: It is a hang up, sir.





K-4  
BN-bn

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30

THE COMMISSIONER: Oh, you do not agree?

MS. KITELY: It is the position we have taken all along that the anticipated evidence statement ought not to be released. We have found in reviewing them that they are not entirely accurate, and in my submission it would be inappropriate to have them released.

We have taken a position that statements that are signed by the witness, and we do not have much to argue about, but certainly the "will says" or the anticipated statements we take vehement objection to release.

MR. BROWN: Mr. Commissioner?

THE COMMISSIONER: Yes.

MR. BROWN: Mr. Scott anticipated my question I had of you. Earlier we made submissions or attempted to make submissions on disclosure of the police report. "Will say" statements and other forms of statements may well be contained in the police report. We are now getting into witnesses who are involved either in the investigation involving my client or the investigation after my client.

We would like some decision very





K-5

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

shortly on whether or not the police report is going to be available because it is apparent that the Crown attorney and the police ---

THE COMMISSIONER: Yes, I think Mr. Lamek right at this instant is still trying to deal with something Mr. Young proposed to him. He is working on it, slowly, I will concede.

MR. BROWN: Well, notwithstanding the objection of counsel for the Registered Nurses' Association to the disclosure of such statements, it has been our position from the beginning that any such statement which may be relevant or may in some way refer to our client should be made available to us in light of its possession by the Crown and by the police.

THE COMMISSIONER: Well, it is not as clear as that. The matter will obviously have to be argued because different positions are being taken. If you and Mr. Scott want to pursue it ---

MR. SCOTT: Well, can I ask that it be argued. I just want to make two points very briefly, first of all.

Other witnesses who have made "will say" statements have had them produced to counsel. Everybody understands they may only be as







K-6

1 accurate as the police officer's recollection or  
2 recording of the event. It is not a signed statement.  
3 That is point one. This is the first time it has  
4 ever been refused. I draw nothing from that.

5 The second thing is that if the  
6 police were giving evidence, I think we would be able  
7 to obtain from the police the "will say" statements  
8 and then it would be absolutely absurd because we  
9 would have to recall witnesses to ask them questions  
10 about them.

11 If the witness says that the "will  
12 say" statement is false, well, that is the end of it.  
13 But that should certainly be said because the police  
14 will be giving evidence later on and may say it is  
15 accurate, I do not know.

16 THE COMMISSIONER: Well, one of the  
17 problems I am faced with, and I do not mind making  
18 a special rule, but so far this witness has not said  
19 anything adverse to anyone that I can think of.  
20 When the matter came up once before, I have forgotten  
21 the circumstances, it was because the witness appeared  
22 to be adverse to Mr. Brown's client, and accordingly,  
23 I made an order for the production of it to him and  
24 to him alone.

25 MR. PERCIVAL: That was Dr.  
Fowler's evidence, Mr. Commissioner.





K-7

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

THE COMMISSIONER: Pardon me?

MR. PERCIVAL: That was Dr.

Fowler.

THE COMMISSIONER: Yes, that is right. I think he had said something or was alleged to have said something, and therefore, it seemed fair to me.

But what is there in -- what do you think there is in the evidence here that you should want to discredit?

MR. SCOTT: Well, it is primarily informational. We have, for the most part, in the case of most nurses and so on, that has not presented any difficulty at all. It is a problem of finding out information. What is the evidence going to be so we can prepare ourselves.

Now, you know, if this lady's counsel takes the position that it will not be revealed, it will be something that you will have to rule on. It is really, it seems to me, a question of whether the police should reveal it. They have it; they made it.

THE COMMISSIONER: But you see, the problem is, I think it is a problem that we all know of, that when the police are investigating they get people to say all sorts of things that are really





K-8

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

totally inadmissible, and as Miss Kitley says, maybe just guesswork or inaccurate or something of that nature.

They do not want that to come out or to be made use of, if it is not going to be admissible evidence. Now, if, though, the witness says something that is adverse to your interests or adverse to Mr. Brown's client's interest, then the situation becomes a question of fairness, a doctrine which you have heard of.

MR. SCOTT: But Mr. Commissioner, on the question of fairness, the police at this stage or at the other stage or both are going to say, this is the information we obtained, we believe it to be an accurate account of what was said, and they are going to, in due course, when we get to that stage put it forward. At that stage, we will have no method of testing whether in fact it is accurate.

For example, let us assume a police officer gets into the witness box and says we made a decision to do this because we had interviewed Miss X or Dr. Y and here is the "will say" statement that shows what we believe they told us. It is then too late to determine ---

THE COMMISSIONER: No, no.





K-9

1

2

MR. SCOTT: Well, you have to  
begin all over again.

4

5

6

THE COMMISSIONER: It is not  
too late. I understand that, but it is a risk that  
the police will have to take, of course.

7

8

9

MR. SCOTT: And then again, we  
look at all their statements and we begin to call all  
those witnesses over again to see if the "will say"  
statements were in fact accurate.

10

11

12

Now, that has not been a problem  
because for the most part there has been fairly  
completely disclosure until we come to this case.

13

14

MS. CRONK: Well, sir, may I just  
add to the discussion on that point.

15

16

MR. SCOTT: However, I leave it  
for you.

17

18

19

20

MS. CRONK: To assist, my  
friend, Mr. Scott's, recollection, with the greatest  
of respect, is in part wrong, as I see it, for this  
reason. The position to date has been this, as Mr.  
Lamek ---

21

22

23

24

25

THE COMMISSIONER: Excuse me  
just a moment. Obviously we will not need you again  
until 2:30. I do not know whether any one of these  
hundreds of lawyers has offered to take you to lunch









K-10

1

2

or anything like that, but if you are going on your  
own, just go and come back by 2:30.

3

4

THE WITNESS: Thank you.

5

---Witness withdraws from the stand.

6

THE COMMISSIONER: All right.

7

MS. CRONK: Sir, you will

8

recall that the position to date, and indeed Mr. Lamek  
many weeks ago put this on the record, has been that  
Commission Counsel, who do have copies of these "will  
say" statements as well as, to the best of our  
knowledge, such signed statements as do exist, have  
provided a copy of those to perspective witnesses and  
their counsel at the time that Commission Counsel  
meet with them to discuss their future evidence.

13

14

15

16

17

18

The only situation of which  
I am aware where one of those "will say" statements  
has been provided to counsel not representing the  
witness was in the instance of Dr. Fowler and the  
allegation concerning Mr. Brown.

19

20

21

22

THE COMMISSIONER: That was  
a special reason because we thought there was a  
possibility that something he had said -- it was more  
than a possibility, it was clear that there was ---

23

24

25

MS. CRONK: The risk of  
prejudice had arisen, sir, that is right.

THE COMMISSIONER: The





K-11

1

2

3

4

problem I am having here is that this witness so far does not seem to have said anything adverse to either Mr. Brown's client or the hospital.

5

6

7

8

9

10

11

12

13

14

MS. CRONK: Well, my purpose in rising, sir, was two-fold. One simply to clarify what the practice to date has been. It is not an exception with this witness. Indeed, it would only be the second instance in which those statements were otherwise produced. But more importantly, sir, is that in addition to Miss Kitley, Commission Counsel would have a difficulty with a ruling which suggested that those statements would be disseminated at large to all other counsel without some degree of selection.

15

16

17

18

19

20

21

22

23

24

25

THE COMMISSIONER: I would just like to know, first of all, supposing the police sought to make use of that statement for their own purposes, first of all, what would your position be then because you would have more trouble, I would think, if the police did want to make use of it, because if they want to make use of that to justify what they did in the second phase, then obviously they have an interest in the production of that document and I doubt very much if I will rule that they could not do it.





-12

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MS. KITELY: Surely that is a Phase 2 problem, sir, and as we have dealt on a regular basis, we are dealing with Phase 1 first and Phase 2 later. We will have to cross that bridge when we come to it.

THE COMMISSIONER: Mr. Percival, you do not know now whether you will want to make use of these "will say" statements?

MR. PERCIVAL: No, I do not. Certainly I have not heard anything -- most of the stuff I have heard this morning so far is very new. I was rather interested in getting the Policy Procedure Manual.

THE COMMISSIONER: Yes.

MR. SCOTT: Mr. Commissioner, with the greatest of respect to my friend, it is not as simple as that.

First of all, with respect to what Miss Cronk says, virtually every nurse has made her "will say" statement available directly, so we have not had to deal through Commission Counsel and we have seen them when those interviews have taken place. So, this is the first instance of which I have record. There may be one or two others where the "will say" statement has not in due course, on a







K-13

1

2

private basis been made available to us.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

It cannot be put off as a Phase 2 matter, because while the statement and the use that the police may make of it is a Phase 2 matter, the matters contained in the statement are a Phase 1 matter. Therefore ---

THE COMMISSIONER: They may be or they may not be. They may be totally inadmissible.

MR. SCOTT: Well, I presume that the police were not interviewing these witnesses about anything except how the babies died. So, presumably the material, if relevant in the statement, is about matters that impinge on how the babies died.

Now, if the statements are introduced, as they may or may not be, in Phase 2 and show that there is evidence about how the babies died that is inconsistent with the evidence you heard in Phase 1 about which by then you will already have had argument, we are going to have to begin all over again.

It seems to me that the question is the statements exist, they are in the possession of one counsel, and it has to be decided if they are going to be made available not on a







K-14

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

wholesale basis, but if they are going to be made available before examination takes place. If they are not, well then, in Phase 2 we may have to reopen the whole thing and ask you to reopen Phase 1.

THE COMMISSIONER: I can see we can have some trouble.

MR. PERCIVAL: Mr. Commissioner, may I be of some assistance?

THE COMMISSIONER: Yes.

MR. PERCIVAL: If my friend would permit me, may I provide to you over the lunch hour the "will say" statement because I am concerned that there are certain comments allegedly attributable to the witness that may be rather embarrassing to her in the event it became something out -- it is the very thing to which you already alluded. Perhaps, Mr. Commissioner, you would look at it, if you wish, if my friends would agree to it, and then you can make your decision.

It is difficult to make a decision on something you have not seen.

THE COMMISSIONER: Yes, that is right. Well, I do not know.

MS. KITELY: Mr. Commissioner, might I respond to that discussion?





K-15

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

THE COMMISSIONER: Yes.

MS. KITELY: I have to say that to be consistent with the position we are taking, you ought not to see the statement either, and quite frankly, for exactly the reason Mr. Percival has indicated.

THE COMMISSIONER: Why do you not want me to read them? Well, you do not need to answer that question if you do not want to. But if you do not want me to read them, is there something there that will be -- what about having Commission Counsel read it? Do you trust anybody?

MS. CRONK: I have, sir.

MS. KITELY: For once Commission Counsel and I agree on something.

Can I deal with why you ought not to hear it, sir?





4/BM/ak

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

We had the argument extensively on whether or not the so-called police report ought to be distributed and one of the factors that came out during the course of that argument was that you had seen it and I think unanimously people virtually jumped to their feet and said if you have seen it we must see it. So, it is for that reason that in my submission that you ought not to see any of the statements.

There are things in the statements, and I can tell you we have seen about 30 of them.

THE COMMISSIONER: Well, I can rise above, at least I hope I can rise above -- there is only a certain amount of room upstairs anyway and I discard things that are inadmissible or irrelevant, believe it or not, I do, I have been trained that way. However, if you don't want me to read it, obviously Miss Cronk has read it.

MS. KITELY: Miss Cronk has read it.

THE COMMISSIONER: Yes. Would it be possible that Miss Cronk would then decide whether anything in there is admissible or is not admissible or is relevant or is not relevant and could delete it? I know we now have some trouble in the deletions.

MS. KITELY: The editorializing of





L2

1  
2 however many statements we've got, sir, is not an  
3 answer to the problem. In my submission this decision  
4 was made when Dr. Fowler was on the stand, you made  
5 it then.

6 THE COMMISSIONER: I made it then  
7 because it was something that had been said by  
8 Dr. Fowler and seemed to me to be adverse to  
9 Mr. Brown's client.

10 MS. KITELY: As you pointed out  
11 several times to my friend, that has not yet happened  
12 and in my submission we ought to await that happening  
13 and argue my friend's submissions at that point.

14 Might I say before sitting down perhaps  
15 before the lunch hour that it is unfortunate that  
16 Mr. Scott has made his remarks about this being the  
17 first time that there has not been full disclosure.  
18 My friend is quite frankly creating an inference that  
19 the doctors, the Hospital and the administration and  
20 so forth having all kinds of information and we get  
21 the first nurse on the stand and there is some element  
22 of failing to disclose.

23 Miss Cronk has indicated this is the  
24 second time the issue has been raised. The irony  
25 of it is, sir, is that Mr. Scott has probably had  
more disclosure from the nurses than anyone else







1  
2 before this Commission.

3 MR. SCOTT: I agree. I entirely  
4 agree with that. We have had complete co-operation  
5 of disclosure. We are now asking for something and  
6 it is being refused and I am taken aback and surprised  
7 and I am sorry about it and if nothing can be done  
8 about it, nothing can be done about it. I want to  
9 register an objection to the proposition that you  
10 should see it and that you shouldn't discharge your  
11 duty by asking Miss Cronk to discharge it. That just  
12 isn't good enough. There is no quote in the land  
13 that applies that principle, even when the privilege  
14 is the Cabinet privilege, the judge is allowed to  
15 see the document and determine whether it has any  
16 relevance. The relevance you will know, sir, is  
17 not only as to whether it is relevant in the terms of  
18 your general inquiry but whether it may be relevant  
19 in terms of examination that other witnesses conduct.

20 Now, we have had full disclosure  
21 and everybody I think has disclosed it fully to  
22 everybody else until this point and that is why I have  
23 to ask you to make a ruling about it.

24 THE COMMISSIONER: Well, I'm not sure  
25 about that. I'm not sure that the statements of  
witnesses given to the investigators have as a





1  
2  
3 general rule been produced to everybody. They have  
4 been produced to the witness; the witness has had  
5 them and the witness' counsel has had them, but I  
6 don't think that the statements of witnesses have  
as a general rule been produced.

7 MR. SCOTT: Not by Commission Counsel.  
8 Counsel for the Nurses' Association is quite right,  
9 we have had an arrangement for example whereby we  
10 have participated from time to time in interviews  
with nurses.

11 THE COMMISSIONER: Well, obviously  
12 if they are your clients.

13 MR. SCOTT: They are not our clients.

14 THE COMMISSIONER: Well, sometimes  
15 they are.

16 MR. SCOTT: That is the disclosure  
17 that my friend has given and that we have talked  
18 about. All I'm saying is that in this case that hasn't  
19 been possible and, therefore, for the first time we  
have to ask you to make that ruling.

20 THE COMMISSIONER: Yes, all right.  
21 Now, Mr. Brown has been trying to get up for some  
22 time, you don't see what goes on behind you. Yes,  
23 all right, what do you want to say?

24 MR. BROWN: If I might simply say  
25





L5

1  
2 this that we have not argued the police report, the  
3 argument was deferred in the hopes there would be a  
4 settlement. The propositions that we wanted to put  
5 forth at that time have not been heard. The basic  
6 proposition is that if there is any statements in  
7 the possession of the police or the Crown Attorneys  
8 that refers directly or indirectly to our client,  
9 that is a matter of basic procedural fairness to our  
10 client and we would wish to see that statement.

11 THE COMMISSIONER: Yes, all right,  
12 thank you. Mr. Labow?

13 MR. LABOW: Mr. Commissioner, I  
14 must support Mr. Scott in his asking for the production  
15 of the statement and I should like to point out to you  
16 that our position at least is that we have neither  
17 the time nor the funding to have the disclosure that  
18 Mr. Scott has available to him to get from these  
19 nurses and we know almost nothing about what they  
20 will say, have said or have to say and any statements  
21 given to anyone or any statement that the police  
22 discuss ---

23 THE COMMISSIONER: But you can't  
24 blanket. Supposing, just supposing one of these  
25 statements said I think Mr. Labow did it. Now, do  
you want that sort of thing to -- unless they have





1

2

3

some evidence, do you really want that sort of thing  
to become public property?

4

5

6

7

8

9

10

11

12

13

MR. LABOW: Well, at the very least,  
Mr. Commissioner, I think that counsel should sit  
down with yourself, counsel for that witness could  
sit down with Commission Counsel and yourself if  
they have any strong objections to anything in the  
statement, and I mean very strong objections, and if  
that is the case they could black it out the way much  
of the evidence and statements that we have received  
have been blacked out. But other than that, I think  
that any statements made should be produced throughout  
the Commission.

14

THE COMMISSIONER: Yes, thank you.

15

16

MR. OLAH: May I assist you,  
Mr. Commissioner?

17

18

19

20

21

22

23

24

25

THE COMMISSIONER: Yes.

MR. OLAH: As I understand in many  
areas such as law of confession where there is  
evidence that is to go in and there is some question  
about it, the trial judge or you and your role as  
Commissioner should and must review the evidence  
that is in issue.

THE COMMISSIONER: Anybody else want  
to say anything before lunch?









L7

1

2

3

I will give this matter some thought  
and we will see. Until 2:30.

4

---Luncheon recess.

5

6

7

8

9

10

11

12

----

13

14

15

16

17

18

19

20

21

22

23

24

25





AA  
BB/cr

1

2

---On commencing at 2:30 p.m.

3

4

5

6

7

8

9

10

11

12

13

14

15

THE COMMISSIONER: On the matter raised just before lunch I am still considering it. Ms. Cronk tells me that she is good with the examination in chief until this afternoon so, there is not an immediate problem. But I think that it is clear that each one of the problems will have to be resolved as it comes up, resolved for that particular one, and notwithstanding Miss Kitley's wishes, I think I will have to look at this particular "will say" statement and I trust that I will be able to make a decision on the matter on Monday and the decision I make then may not be a final one because matters may develop which will change my views.

16

17

18

19

20

21

22

23

24

25

Yes?

MR. BROWN: If I can make our position clear. The reason we are seeking disclosure of the statement is in order to guarantee an element of procedural fairness to our client because we have reason to suspect, although it may not be the case, that there are references to our client in that statement. It is not our submission that this statement should be made available to all counsel.

THE COMMISSIONER: No, I understand





1

2

that.

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

MR. BROWN: It is a submission simply that it be made available for the use of counsel whose clients are affected or referred to in this statement and indeed we would object to a general provision of the statement to all counsel, and it goes of course without saying we would object to it being made an exhibit at this point.

THE COMMISSIONER: Yes. Well, it may be released to one, two or all counsel, depending on the circumstances.

Yes, Mr. Shinehoft?

MR. SHINEHOFT: Well, I take issue with that, Mr. Commissioner. We as parent's counsel I feel I should be entitled to these statements as well because it may directly affect our involvement in this matter. It may affect our involvement in respect to the information that is available to us and to assist us in the purposes of cross-examination of this witness or other witnesses and I would submit, Mr. Commissioner, that if you are going to release the document to my friend Mr. Brown, it should be released to everyone.

THE COMMISSIONER: Yes. Well, that may be what happens, it may not be, it depends. We





1

2

are talking in circles because I don't know what's  
in it.

3

4

MR. SHINEHOFT: Neither do I.

5

6

7

MS. KITELY: Before leaving the  
topic, sir, you have indicated you plan to make  
a decision on Monday morning. That is when Dr.  
Kauffman will be here and I wonder if you ...

8

9

THE COMMISSIONER: Tuesday morning  
you would rather have?

10

11

MS. KITELY: That is exactly what I  
was thinking.

12

13

THE COMMISSIONER: Nothing I like  
better than procrastination. All right, okay,  
well then, Miss Cronk.

14

15

MS. CRONK: Q. Thank you, sir.

16

17

18

19

20

21

22

Ms. Browne, before we broke for  
lunch you will recall that we were discussing the  
provisions of Section 28.41 of the Nursing Manual  
which speak to authorized activities which may be  
performed by registered nursing assistants and one  
of those not specifically mentioned before lunch  
is that they are authorized to participate in the  
care of a patient during a convulsion. Do you  
see that?

23

24

25

A. Yes.







1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. And as well you will recall I drew your attention earlier to the authorized activity that they may participate in the basic care of a patient with an intravenous. Do you see that?

A. Yes.

Q. I would ask you now if you would turn to the provisions of Section 28.42 of the Manual which, as I read them, are provisions specific to the participation of registered nursing assistants in matters involving intravenous therapy. Do I have that correctly?

A. Yes.

Q. And the introduction to that section indicates that when a registered nursing assistant is caring for patients with IVs the following is a list of activities in which he or she may perform, and I don't propose to go through all of them, but I would draw your attention to that set out on your (d) slowing down an IV running too rapidly if the registered nursing assistant reports to a registered nurse immediately. Am I reading that correctly?

A. Yes.

Q. And under (e) and in an





1  
2 emergency situation a registered nursing assistant  
3 may reconnect intravenous tubing if it suddenly  
4 becomes disconnected so long as he or she reports  
5 to a registered nurse immediately?

6 A. Yes.

7 Q. And then if we look at (k)  
8 A registered nursing assistant may anticipate when  
9 intravenous may run dry and notify a registered  
10 nurse. If a registered nurse is not available to  
11 fill the buretrol, the IV may have to be clamped  
12 off.

13 Reading those provisions together,  
14 Ms. Browne, am I correct in concluding that there  
15 are very limited functions which a registered  
16 nursing assistant was authorized to perform with  
17 respect to IV therapy generally and, more specifically,  
18 with respect to IV apparatus?

19 A. Yes.

20 Q. All right. And they could  
21 not for example start an IV, you told me previously?

22 A. No.

23 Q. And from these provisions I  
24 take it really that they could do no more than stop  
25 an IV only in the circumstances where the IV may  
have run dry?





1

2

A. Yes.

3

Q. And in all of the situations

4

outlined under Section 28.42, if they took any

5

action with respect to IV apparatus they were

6

required by the official policy of the Hospital

7

to immediately inform a registered nurse. Do I

8

have that correct?

9

A. That is correct.

10

Q. And I take it that that

11

would be so by virtue of the fact that registered

12

nurses as distinct from registered nursing assistants

13

are authorized for example to start an IV and to

14

deal with the apparatus once it has been connected

15

to a patient?

16

A. They are not authorized to

17

start an IV unless that is a special procedure that

18

they are certified to do.

19

Q. All right, I am sorry.

20

A. But they are certified to

21

care for the IV once it has been started.

22

Q. And would that include

23

restarting the IV if it had been for some reason

24

become disconnected?

25

A. No.

Q. In those situations who would







1

2

be the appropriate person to contact about a  
disconnected or obstructed IV line?

3

4

A. If it is disconnected, can  
I show you again?

5

6

Q. Yes, please do.

7

A. If it is disconnected it  
generally would be disconnected at this point.

8

This is the needle and the small section of tubing

9

that goes into the patient. So, it is just this

10

section right here that would actually be into

11

the patient and this part is just a small connection  
by the needle.

12

13

Q. You are pointing to the very  
bottom of the IV line?

14

A. Yes.

15

Q. All right.

16

A. If an IV becomes disconnected  
because this is a closed system, if you will, once  
it is all connected to start with it is a closed  
system. When they speak of disconnection it would  
be disconnected at this point. So that it could  
be reconnected. If an IV has to be restarted it  
means that the needle is not functioning for the  
patient and it would be removed.

23

Q. I see. So then I take it that

24

25





1  
2 a registered nurse could restart the IV by re-  
3 clamping the bottom part to the tubing but she could  
4 not insert a fresh needle or otherwise deal with the  
5 needle at the site of the patient's body?

6 A. She could reconnect but she  
7 couldn't restart.

8 Q. All right, thank you. Could  
9 you next, Ms. Browne, look if you would please to  
10 Section 28.44 of the manual which deals with  
11 functions by registered nursing assistants not  
12 requiring a policy statement. I confess to you  
13 some confusion as to the meaning of that title but  
14 I take it that the matters set out in this section  
15 are as well authorized activities that may be  
16 performed by a registered nursing assistant in the  
17 Hospital?

18 A. Yes.

19 Q. All right. Could registered  
20 nursing assistants insofar as you are aware perform  
21 these kinds of functions as well on Wards 4A/B?

22 A. Yes.

23 Q. All right. Registered  
24 nursing assistants on those floors then I take it  
25 could care for a patient who was on either a  
cardiac monitor or what is described as a Holter





1

2

monitor?

3

A. Yes.

4

5

6

Q. And we have had that very  
early on in earlier evidence, Ms. Browne, but  
perhaps you could explain to us again what a Holter  
monitor is?

7

8

9

A. It is a way of monitoring a  
patient over a period of time and it is like a tape  
recording.

10

11

Q. And how is that distinct from  
a cardiac monitor?

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. A cardiac monitor is not  
a portable as such, a piece of equipment attached to  
the patient which does give you a visual read-out.

- - - -





BB  
DM/cr

1

2

Q. So the Holter monitor gives

3

you a tape recording not a visual reading?

4

A. That is correct.

5

Q. Would a registered nursing

6

assistant insofar as you are aware be trained to

7

read and interpret the printouts from either of

8

those two kinds of monitors?

9

A. No.

10

Q. Simply to observe that the

monitor was functioning and the read out was being

11

obtained?

12

A. Yes.

13

Q. And similarly could registered

nursing assistants then on Wards 4A/4B care for

14

patients who were on apnea monitors?

15

A. With supervision.

16

Q. The reason I specifically

17

asked you that question Miss Browne is you will

18

note beside that particular entry in this section

19

is an indication that I took to mean that it applied

20

only to Wards 7F and 7G, that is the Neonatal

21

Wards.

22

A. Yes.

23

Q. Nonetheless on Wards 4A/4B

registered nursing assistants could with supervision

24

25







1

2

attend the patients who were on those kinds of  
monitors?

3

4

A. That became a necessity  
sometimes.

5

6

Q. Necessity by virtue of avail-  
able staff?

7

A. Yes.

8

9

Q. And similarly as I understand  
it, Miss Browne, there were a number of activities  
which were strictly prohibited from performance  
by registered nursing assistants, and those I suggest  
are set out in Section 28.45 of the Manual. We  
see that amongst the prohibited activities by  
registered nursing assistants are calculations of  
medication dosages?

10

11

12

13

14

15

A. Yes.

16

Q. Is that correct?

17

A. Yes.

18

19

Q. Now, you told us before the  
break about a particular kind of situation which  
might arise on Ward 4A/4B where a registered nursing  
assistant might be called upon to administer an  
oral medication. Do you recall you suggested and  
you described the situation as one where the patient  
might feel more familiar or comfortable with a

20

21

22

23

24

25





3  
1  
2 registered nursing assistant, and in that case the  
3 administration by the R.N.A. might in fact be  
4 permitted.

5 In the face of this policy, to the  
6 best of your knowledge was there ever a situation  
7 that arose on 4A/4B where a registered nursing  
8 assistant was permitted to actually calculate and  
draw up her medication for any patient?

9 A. No.

10 Q. And similarly under this  
11 policy, that is the policy set out in Section 28.45,  
12 I take it that registered nursing assistants were  
13 not permitted, as you have just indicated, to  
14 prepare, pour, deliver or record medications?

15 A. That is correct.

16 Q. Did that extend as well to  
17 the recording in the medical record or medical chart  
18 of any given patient, the recording of actual  
19 medications that had been ordered and administered  
for a particular patient?

20 A. Yes.

21 Q. Was charting in that sense  
22 then solely the responsibility of a registered nurse?

23 A. Yes.

24 Q. And as well, continuing with  
25





1  
2 Section 28.45 we see that registered nursing  
3 assistants were prohibited from hanging blood or  
4 IV solutions?

4  
5 A. Yes.

6 Q. Do I correctly take from  
7 that, Miss Browne, to mean confirmation of what  
8 you told us earlier that registered nursing  
9 assistants could not actually connect an IV bag  
10 solution, or the IV bottle which might contain the  
11 IV solution?

12 A. That is correct.

13 Q. And similarly if we look to  
14 the bottom of Section 28.45 we see a specific  
15 prohibition against registered nursing assistants  
16 inserting, removing, or what is called irrigating  
17 duodenol or nasogastric tubes?

18 A. That is correct.

19 Q. Apart from the policies which  
20 are set out in the Hospital Department of Nursing  
21 Manual with respect to authorized activities both  
22 for registered nurses and registered nursing  
23 assistants, Miss Browne, are the activities in  
24 which either kind of nurse could participate  
25 regulated as well by the Ontario College of Nurses?

A. Yes.







5

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. And in terms of the regulations which are set out by the Ontario College of Nurses, are certain kinds of activities authorized or prohibited by virtue of the licence to practice that is granted to a registered nurse or a registered nursing assistant?

A. Yes.

Q. And during the course of your career, both as a registered nurse and as a Clinical Nurse Specialist, have you had occasion to familiarize yourself with the Standards of Nursing Practice that have been set out by the College of Nurses of Ontario both for registered nurses and registered nursing assistants?

A. Yes.

Q. Miss Browne, I am showing you a pamphlet or a booklet described as "Standards of Nursing Practice for Registered Nurses and Registered Nursing Assistants", published by the College of Nurses of Ontario. There is an indication on the front cover that it was first approved in June of 1976 and updated in April of this year. Have you seen these Standards previously?

A. Yes.

MS. CRONK: May that be the next





1

2

exhibit please, Mr. Commissioner.

3

THE COMMISSIONER: Exhibit 292.

4

---EXHIBIT NO. 292: Standards of Nursing Practice  
for Registered Nurses and  
Registered Nursing Assistants,  
College of Nurses of Ontario,  
June 1976-1983.

5

6

Q. These standards as I understand

7

it, Miss Browne, define amongst other matters the

8

basic nursing skills that are expected and required

9

both for a registered nurse and a registered nursing

10

assistant, do I have that correctly?

11

A. That is correct.

12

Q. And I would ask you to turn

13

first if you would to page 24 of the Booklet.

14

As I understand it there are two types of basic

15

nursing skills defined by the College. First

16

B Level Skills, and I take it that those refer to

17

skills which any particular nurse has been taught

18

both in an academic or a theoretical sense, and

19

as well in respect of which he or she might have

20

had practical experience, do I have that correctly?

21

A. That is right.

22

Q. Then the second category

23

of basic skills are those described as A Level Skills

24

which are those which a nurse or a nursing candidate

25

has, in respect of which a nurse has received





1  
2 particular theoretical or academic training but  
3 which she may or may not have had an opportunity  
4 to actually practice, do I have that correctly?

5 A. That is true.

6 Q. If we look at page 24 of the  
7 chart dealing with Basic Nursing Skills, we see  
8 on the top of the columns set out a column both  
9 for Registered Nurses and Registered Nursing  
10 Assistants, and in both underneath the letters  
11 A and B. Do I take those letters to refer to  
12 A Level Basic Skills; and B Level Basic Skills?

13 A. Yes.

14 Q. Well, for our particular  
15 purposes, Miss Browne, I am interested first in  
16 the provisions which are set out concerning charting  
17 in a written form, and I take it that both a  
18 registered nursing assistant and a registered nurse  
19 insofar as the College of Nurses is concerned is  
20 expected to be able to chart in written form with  
21 respect to patients?

22 A. That is correct.

23 Q. But when we come to the matter  
24 of transcribing written physician's orders, it is  
25 expected that only registered nurses will have those  
basic skills and not registered nursing assistants?





1

2

A. That is correct.

3

Q. Quite apart from the

4

expectations of the College with respect to the

5

basic skills of either a registered nurse or

6

a registered nursing assistant, would a registered

7

nursing assistant, for example, be prohibited by

8

the College from participating in the transcribing  
of written physician's orders?

9

A. Yes.

10

Q. That would be I take it a

11

condition of his or her licence?

12

A. Yes.

13

Q. And if we move ---

14

THE COMMISSIONER: I am sorry, I am  
being a little slow on this. Even a registered  
nurse unless they have had special training, am I  
right?

17

Q. Unless they had A Level Skills?

18

A. That is correct.

19

THE COMMISSIONER: That would mean  
they would have to have some special course over  
and above their RN Certificate?

21

THE WITNESS: Yes,

22

MS. CRONK: Q. I would ask you to

23

turn now if you would to page 26 of the same chart,

24

25







1  
2 Miss Browne. We see there that the subject of  
3 medications is dealt with. Please correct me if  
4 I am wrong, I took it from the first entry on that  
5 chart that only registered nurses with B Level  
6 Skills are expected, or in the eyes of the College  
7 permitted to prepare and administer medications  
8 by any of the routes set out, and that includes  
9 the oral route, intramuscular routes, or intravenous  
10 routes above the drip chamber on the IV apparatus,  
do I have that correctly?

11 A. That is correct.

12 Q. Once again only registered  
13 nurses, but this time a registered nurse with  
14 either A Level Skills or B Level Skills is expected  
15 or permitted by the College to engage in the  
16 preparation and administration of narcotic and  
controlled drugs, is that correct?

17 A. Yes.

18 Q. Or the calculation of dosages  
19 per se?

20 A. Yes.

21 Q. And once again a registered  
22 nursing assistant, as we see, is not expected by the  
23 College to have those skills, does it necessarily  
24 follow that a registered nursing assistant is  
25





1  
2 prohibited from engaging in those forms of activity?

3 A. She would be prohibited.

4 Q. I take it that apart - I  
5 am sorry, perhaps you could turn to page 29 before  
6 we leave this area. We see there the subject of  
7 resuscitation measures set out, and dealing with  
8 the matter of external cardiac massage, am I  
9 interpreting the chart correctly that a registered  
10 nurse with B Level Skills, and a registered nursing  
11 assistant with B Level Skills are both expected to  
12 be conversant with that form of resuscitation  
13 measure and are permitted to engage in it?

14 A. That is correct.

15 Q. Subject of course to the  
16 applicable policies of the Hospital in which they  
17 are employed?

18 A. Yes.

19 Q. I take it, Miss Browne,  
20 that quite apart from the basic level skills which  
21 the College might expect, or require for registered  
22 nurses and registered nursing assistants, there are  
23 over and above the basics additional skills which  
24 either candidate could acquire and become licensed  
25 therefore in a rather different and special way  
than a registered nurse who only has basic skills?





1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

11

A. That is correct.

Q. If we turn for example  
to page 32 of the booklet, we see set out there  
certain added nursing skills for registered nurses,  
do you see that?

A. On page 32?

Q. I am sorry, it actually starts  
on page 31.

A. Yes.

Q. And the next pages as I  
understand it outline additional nursing skills  
which any given registered nurse might acquire?

A. Yes.

Q. Would I be correct in assuming  
that would require a special form of certification  
from the College?

A. Yes.

Q. Would that as well, if a nurse  
at any given time had taken the appropriate courses  
to become certified with respect to these additional  
kinds of tasks, would that then be reflected in her  
licence as well that she was qualified to do those  
kind of activities?

A. I am not sure, I would expect  
it would, but I can't say for sure.







1  
2 Q. Could you turn for example  
3 to page 32 and perhaps the meaning of the question  
4 will become more clear. We see there amongst the  
5 additional skills outlined several dealing with  
6 parenteral lines, venous lines, peripheral IV,  
7 and it indicates that a registered nurse can become  
8 trained in adding medications below the drip  
chamber on an IV apparatus.

9 A. Yes.

10 Q. Is that a procedure which in  
11 the normal course a registered nurse would not be  
12 trained in but in which she could be trained if  
she sought to be?

13 A. Yes.

14 Q. And similarly if you read on  
15 under venous line central for measuring central  
16 venous pressure, or for total parenteral nutrition  
17 a registered nurse could if she or he wished to be  
18 trained in adding medications below the drip  
19 chamber for the purposes of that form of IV apparatus  
as well?

20 A. Yes.

21 Q. And similarly are there added  
22 nursing skills which any given registered nursing  
23 assistant can take up quite apart from the basic  
24  
25





Browne, dr.ex.  
(Cronk)

1  
2 skills that they are taught during the course of  
3 their formal academic training?

4 A. Yes.

5 Q. Are those set out on pages  
6 34 and 35?

7 A. Yes.

8 Q. My reading of this Miss Browne,  
9 and correct me if I am wrong, I do not see any  
10 reference to the administration of medications at  
11 any point on an IV line, be it below the drip chamber  
12 or above it?

13 A. That is correct.

14 Q. Can we turn now -

15 THE COMMISSIONER: Do I understand  
16 correctly that the College of Nurses apparently  
17 would allow a registered nurse, properly trained,  
18 to add to the line below the buretrol, but the  
19 Hospital for Sick Children will not?

20 THE WITNESS: That would be my  
21 understanding.

22 THE COMMISSIONER: No matter how well  
23 trained the nurse was, I take it?

24 THE WITNESS: I don't know of any  
25 areas in the Hospital where that is allowed, that  
may be the limitation of ---





1

2

THE COMMISSIONER: It seems to be  
though as far as 16 ---

3

4

MS. CRONK: 16.06, sir, I believe.

5

THE COMMISSIONER: 16.06.

6

MS. CRONK: You will recall there  
was a provision which indicated that in certain  
locations in the Hospital most notably the Intensive  
Care Unit.

7

8

9

THE COMMISSIONER: There was an earlier  
one, the one we had all the fuss about.

10

14

11

MS. CRONK: Section 18.01 and 18.02,  
sir.

12

13

THE COMMISSIONER: Because it seems  
to be prohibited, or at least that is what you told  
me it was prohibited under the rules.

14

15

THE WITNESS: Yes.

16

17

THE COMMISSIONER: No matter how  
well trained.

18

19

20

21

22

23

THE WITNESS: Yes. Each institution  
would, as well as the College having its stand, if  
indeed a nurse is going to perform those special  
procedures within that institution, the institution  
has to indeed certify her as well and legally cover  
her to do that and the policy of the Hospital is  
not to.

24

25





1  
2 THE COMMISSIONER: No nurse would  
3 ever be allowed to add anything to the IV line  
4 below the buretrol, isn't that the case?

15  
5 THE WITNESS: That is right, and  
6 that is what the policy says.

7 THE COMMISSIONER: Certainly there  
8 is nothing prohibiting it by the College of Nurses,  
9 when I say nothing prohibiting it, if the nurse is  
especially trained she is allowed to do that.

10 THE WITNESS: That is right.

11 THE COMMISSIONER: You may not be able  
12 to answer this. Is there any particular reason  
13 why the Hospital for Sick Children would not  
14 allow - you don't have to answer that question if  
15 you don't want to, but I thought perhaps you might  
16 just know, is it because their standards are higher  
or is it ---

17  
18  
19 - - - - -  
20  
21  
22  
23  
24  
25







CC/BN/ko

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

THE WITNESS: I cannot answer that honestly. I wonder if it has to do with pediatrics.

THE COMMISSIONER: Yes, but they have pediatric departments in almost every hospital, do they not? And this does not say anything about --

MS. CRONK: Q. So that I at least am clear on the matter, Ms. Browne, based on the provisions of the Manual that we have looked at, it is my understanding there is no specific prohibition in the Manual preventing registered nurses from administering medications below the drip bulb or the buretrol, but you have told us that in practice that was the case in the hospital and it did not happen; do I have that correctly?

A. No, according to the Manual that is not allowed.

Q. All right. I am sorry, perhaps you can help me with that, and this may simply be a matter of interpretation, because as I read Sections 18.01 and 18.02 there is specific permission or authority granted, if you will --

THE COMMISSIONER: I think the poor witness is entitled to legal advice before she answers that question. I tried that out and Mr. Scott immediately came to her defence earlier. I agree with





1

CC 2

2

you, I do not think there is, but I do not think this  
poor witness should be forced to agree with us without --

3

4

MS. CRONK: Well, I will leave the  
matter then.

5

6

THE COMMISSIONER: Without some  
assistance.

7

8

MS. CRONK: And hearing nothing from  
Mr. Scott's corner at the moment --

9

10

THE COMMISSIONER: No, he is not  
there.

11

MS. CRONK: That is possibly why.

12

13

14

15

Q. We have heard, Ms. Browne, in  
other evidence that prior to March 21st, 1981,  
digoxin was not a controlled drug on Wards 4A/4B at  
the Hospital for Sick Children. Does that accord with  
your understanding of the situation?

16

A. Yes.

17

18

19

20

Q. As I understand it, during the  
nine month time period with which we are interested,  
there was one central nursing station on Wards 4A/4B;  
is that correct?

21

22

Q. Now, how many medication rooms  
were there then on those two wards?

23

24

25

A. There were two medication rooms,





CC 3

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

one for 4A and one for 4B.

Q. And where were they physically located?

A. Adjacent to the common nursing station.

Q. One on each side?

A. Yes.

Q. If a drug was not a narcotic or a controlled drug on those two wards, to the best of your knowledge, were there any special procedures which applied prior to the evening of March 21st, 1981 which regulated access to those non-controlled drugs?

A. No.

Q. For example, you have told us that there were two medication cabinets. Were they kept routinely locked?

A. Yes -- no. The narcotic cupboard was locked. The other medication cabinets were not locked.

Q. I am sorry, to be fair to you, I think you said there were two medication rooms?

A. Yes.

Q. In each of those rooms was there a medication cabinet?

A. Yes.





CC 4

1

2

Q. And in addition to that was  
there a narcotics cabinet?

3

4

A. Yes.

5

Q. And only the latter were kept  
routinely locked?

6

7

A. Yes.

8

Q. Who would, as a normal routine,  
have access to the medication cupboard in both  
medication rooms on those wards?

9

10

A. Any of the nursing staff and  
the pharmacist.

11

12

Q. And presumably any physician  
who was attending on the ward?

13

14

A. Yes.

15

Q. Or anyone else who was attending  
on the ward, part of the hospital staff?

16

17

A. Within reason, I guess. Indeed,  
it was not a locked room.

18

19

Q. With respect to non-controlled  
drugs and non-narcotic drugs, prior to March 21st,  
1981, was there any special signing procedure in place  
on Wards 4A/4B of which you are aware that was to be  
followed when a medication was withdrawn for use from  
either of those medication cupboards?

20

21

22

23

A. If it was not controlled?

24

25







1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

CC 5

Q. A non-controlled drug?

A. No.

Q. With respect to narcotics and controlled drugs, however, I take it there were rather special procedures which applied to accessing those drugs and regulating the withdrawal of drugs from the narcotics cupboard; do I have that correctly?

A. Yes.

Q. All right. Could you turn to Section 15.01, if you would, of the Manual, please.

Section 15.01 of the Manual, Ms. Browne, applies to the counting of narcotics and controlled drugs, and it provides that:

"1. The Head Nurse is responsible for the narcotic count on the ward.

2. The responsibility of the narcotic count, and carrying the keys, may be delegated by the Head Nurse to the team leader who will be working a twelve-hour shift.

3. The Nurse who counts the drugs at the beginning of the shift must count with the Nurse coming on duty for the next shift.

4. Both Nurses who count the drugs





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

must sign their names beside the  
count in the Narcotic Count Book."

To the best of your knowledge, does that policy and  
the four parts of that policy accurately reflect the  
procedures which in practice were followed on Wards  
4A/4B during the nine month period with which we are  
concerned concerning narcotics and controlled drugs?

A. Yes.

Q. We have had evidence from other  
witnesses as to a number of the aspects of this matter,  
but during the evening of March 21st, 1981, when  
digoxin was directed to be treated as a controlled  
drug, I take it you were at the hospital then in the  
sense that you were still the clinical nurse  
specialist on the cardiology ward?

A. I was still on staff, yes.

Q. Were you on duty that weekend?

A. No.

Q. To the best of your knowledge  
are the procedures which we have just reviewed under  
Section 15 those which would necessarily have applied  
to digoxin once the direction was given that it be  
treated as a controlled drug?

A. Yes.

Q. If we turn to Section 15.03 --





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

THE COMMISSIONER: Before we leave that, it is all very well to count the drugs, but what do they do about it? Supposing the nurse coming on counts the drugs with the nurse who has left and then she counts the drugs with the nurse coming on in the next shift; is that right?

THE WITNESS: That is right, it would be the same nurse who counts each time.

THE COMMISSIONER: But just counting the drugs does not mean anything. What do they do after they have counted them? What do they do with them then? Do they check them with the amounts that are supposed to be dispensed?

THE WITNESS: Yes.

THE COMMISSIONER: It does not say so, does it?

MS. CRONK: Q. Well, if I can --

THE COMMISSIONER: No, but I am just curious. That is the purpose of it, surely, is to say there are so many ampules of digoxin here and there were so many when I came on, and here is what I have done with them; is that not the idea?

THE WITNESS: Yes.

THE COMMISSIONER: They do not ask them to do that, do they?





CC 8

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

THE WITNESS: It is implied in the count.

MS. CRONK: Well, I am sorry, perhaps I have misunderstood, but could I review the procedures, and please tell me where and if I go wrong.

Q. As I understood it, the head nurse at the beginning of the morning shift, unless she delegates that authority to one of her team leaders, is responsible to manually do a count of all narcotics on the ward?

A. That is right.

Q. When she then completes her shift later in the day, is the senior nurse then coming on duty for the evening shift required to do and to repeat the same form of manual count of all narcotics then on the ward?

A. That is right.

Q. And do they do that together?

A. Yes.

Q. And are they both then required to sign their names in the narcotic count book indicating that that check has been done?

A. Yes.

Q. If there is a discrepancy between







1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

CC 9

the quantity of drugs that were recorded in the morning by the head nurse at the beginning of the shift when compared with the number of drugs that were administered during the day shift, are they not then required to follow the procedure outlined in Section 15.02?

A. Yes.

MS. CRONK: Perhaps your question, sir, was directed to how they go about recording the drugs actually administered during the shift.

THE COMMISSIONER: I do not see any requirement to do that.

MS. CRONK: Q. Well, can you tell us, Ms. Browne, as you know it to be, what the practice was for maintaining a master form of recording of all the drugs that were administered during any particular shift?

A. There would be a sheet for each narcotic, and when a narcotic was prescribed, the order was followed, the medication was withdrawn from the narcotic cupboard, it would be drawn up, double checked by another nurse, would be signed off on that sheet so that if there had been 15 ampules before, they then would sign that there were 14.

So when they counted at the end of the





CC 10

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

shift and the count was 14, indeed, that coincided with what had been recorded. If the count was 13, then there was obviously an ampule missing that had not been recorded. So indeed, you would move to what do you do when there is a discrepancy.

Q. And what were the nurses required to do if there was a discrepancy on any particular count at the beginning of any shift?

A. They would have to report that.

Q. By that, if we take a look at Section 15.02, paragraph 1, we see that the formal policy was that:

"1. Any discrepancy in the narcotic count is to be immediately investigated and an incident report completed."

A. Yes.

Q. Was that the procedure to the best of your knowledge, that was in place on Wards 4A/4B in the event of a narcotics count discrepancy?

A. Yes.

THE COMMISSIONER: Is that procedure that you have just described, is that set forth in the regulations?

MS. CRONK: Yes, sir, that is Section 15.02, paragraph 1, recording of a discrepancy.





CC 11

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

THE COMMISSIONER: No, that is clear, but the procedure about keeping the drug sheet, is that set forth anywhere?

THE WITNESS: I do not believe it is in the Policy Manual.

MR. OLAH: I am sorry, Mr. Commissioner, I did not hear what that reference was.

THE COMMISSIONER: Well, I am concerned - you see, the only way that you can reconcile these two drugs is by knowing how much has been used, but so far at any rate, I have not been referred to any regulation requiring the keeping of this drug list.

MS. CRONK: I am sorry, sir, Ms. Kitley, and I am grateful to her, correctly points to Section 15.07 of the Manual, which I think in part speaks to the problem.

Q. Would you look at that as well, Ms. Browne, please?

A. Yes.

Q. It provides in paragraph 1:

"1. The Auditor of the Division of Narcotic Control requires that the column headed 'Balance' be completed on the Narcotic Record Sheet each time a narcotic or controlled drug dose is recorded."







CC 12

1

2

Is that the sheet that you were talking about?

3

A. Yes.

4

5

6

7

Q. You have told us that on the removal or withdrawal of any particular narcotic or controlled drug from the cabinet, that sheet -- a notation had to be made on the sheet and the registered nurse's signature had to be appended to the sheet?

8

A. Yes.

9

10

11

Q. But that the counting reflected the balance left after the removal, not the amount removed; do I have that correctly?

12

A. That is right.

13

MS. CRONK: Does that assist you, sir?

14

15

THE COMMISSIONER: Yes, there is no question it assists me. I am not so sure it solves the problem.

16

17

18

19

20

21

22

It is nice of the Auditor to require that this be done. He does not seem to say who it is to be done by, but I assume that each time a nurse takes a drug to administer it to a child, she enters it upon a sheet and that sheet is the one that the nurse, the new nurse coming in requires to see the sheet for each drug, and then she counts the remaining drugs; is that right?

23

THE WITNESS: That is right.

24

25





CC 13

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

THE COMMISSIONER: I am leading you something awful and you do not have to -- just because you think I want you to give that answer you do not have to give it. I want you to tell me what really does happen.

THE WITNESS: That is what happens. It is a column sheet with the date, the time, the child's name, the doctor who ordered, the order, and there would be a place to record if only part of an ampule is used and the rest is discarded.

THE COMMISSIONER: Yes. How do you record the new drugs coming in? I mean, presumably, as things are getting low, the head nurse or team leader or someone would order up from the pharmacy. That is recorded somewhere too, is it? How do you know --

THE WITNESS: When medication comes from pharmacy, narcotics, they come with a sheet that tells you what you are starting with and the date.

THE COMMISSIONER: Yes, all right.

MS. CRONK: Q. We have seen from Section 15.01, Ms. Browne, that the head nurse on the ward was responsible for actually doing the narcotic count, but that she could delegate that responsibility to a team leader; do I have that correctly?





CC 14

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

A. Yes.

Q. And if we turn to Section 15.03, we see there, do we not, the policy that the registered nurse who does the actual narcotic count bears the responsibility for handling the narcotic keys?

A. That is correct.

Q. Would I then correctly take that to mean either the head nurse or if she delegated the matter to a team leader, the team leader would be responsible for the control of those keys?

A. That is right.

Q. What then would be the procedure on those wards if any particular registered nurse who was not the head nurse and not a team leader to whom that authority had been delegated required the use of a narcotic to administer to a child? How would she go about getting that drug?

A. She would either see that the team leader or the head nurse go with her to unlock the narcotic cupboard and co-sign the medication, or if that person was not available, she would ask for the key.

Q. On occasion, then, if neither the head nurse nor the responsible team leader were available, I take it that any registered nurse on the





CC 15

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

floor could seek and obtain the narcotic keys from  
the nurse who had the responsibility for them?

A. That is correct.

Q. And could then withdraw the  
appropriate medication from the narcotic cupboard, and  
if she followed the policy set out in the Manual,  
record that she had withdrawn it and then proceed to  
administer the medication?

A. She would have to seek another  
nurse to witness that and co-sign for her.

Q. What would the other nurse be  
witnessing, the withdrawal of the drug?

- - - -







DD/BB/ko

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

A. The taking of the drug from the  
narcotic cupboard.

Q. Yes?

A. And indeed the withdrawing of  
it by syringe or whatever route, that the appropriate  
amount had been taken and they would both sign that  
and she would also check that with the doctor's order.

Q. All right. And was it then her  
responsibility to return the keys to the head nurse  
or the delegated team leader from whom she had  
obtained them?

A. Yes.

Q. If a medication was required on  
Ward 4A/B after the pharmacy had closed at the end of  
the day, do you know what procedures applied on Wards  
4A/4B for the obtaining of that medication?

THE COMMISSIONER: Are we talking  
about narcotics?

MS. CRONK: Then we should deal with  
it in two stages. Let's deal first if we could with  
narcotics and control drugs.

THE WITNESS: I am not as clear about  
that, I think you might be better to ask the head  
nurse.

MS. CRONK: Q. Fair enough, we can





DD 2

1

2

ask that of other witnesses.

3

A. Yes.

4

Q. Are you familiar with the  
procedures that applied with respect to non-control  
drugs?

5

6

A. My understanding of that was  
that the evening supervisor would go to pharmacy to  
get the medication.

7

8

Q. All right.

9

10

THE COMMISSIONER: But so far as  
obtaining the drug itself, the nurse would just simply,  
if it is a non-control or narcotic drug, she would just  
go and get it, isn't that right?

11

12

13

THE WITNESS: No, because she wouldn't  
have access to pharmacy after hours.

14

15

THE COMMISSIONER: No, no, I am  
talking about if she wanted it out of the medications  
room.

16

17

18

THE WITNESS: If it was not a  
narcotic?

19

20

THE COMMISSIONER: Yes.

21

THE WITNESS: Yes.

22

THE COMMISSIONER: And all of this  
checking, up until the 21st of March, 1981, applied  
only to narcotics and digoxin was not a control or

23

24

25





DD 3

1

2

narcotic drug until March the 20th, was it?

3

MS. CRONK: 21st, sir.

4

THE COMMISSIONER: 21st.

5

MS. CRONK: Saturday evening.

6

THE WITNESS: Yes.

7

THE COMMISSIONER: So that I take it

8

any nurse, any nurse's assistant or anyone could go  
into this room, the room itself was not locked?

9

THE WITNESS: That's right.

10

THE COMMISSIONER: And could obtain

11

whatever drugs were needed and there was no check with  
the new nurse coming on as to what had been dispensed  
of those drugs, is that right?

13

THE WITNESS: That's correct.

14

MS. CRONK: I was directing my

15

question as well, sir, to the situation where a

16

particular non-controlled drug was required and

17

there was no available stock on the ward.

18

THE COMMISSIONER: I know that, and

19

they had to go to the pharmacy, yes.

20

MS. CRONK: Q. And in that situation,

21

could I ask you to look at Section 14.05 of the Manual,  
Ms. Browne?

22

A. Yes.

23

Q. The first paragraph of that

24

25







DD 4

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

provides that if the medication was required when the pharmacy was closed, the resident on the ward which required the drug, together with a nursing co-ordinator, could dispense the drug from pharmacy?

A. Yes.

Q. Now, to the best of your knowledge, was that the practice which applied on Ward 4A/4B if the drug was required and there was insufficient ward stock available?

A. It would depend on availability of resident, and there were times when, for time involvement, the nurse would borrow from another ward.

Q. Well, that was my point.

A. Yes.

Q. We have heard in evidence from other witnesses that on occasion if a medication was required, again, non-controlled drug, that a nurse in certain situations could simply borrow it from another ward, bring it back and administer it?

A. Yes.

Q. In those situations are you familiar with the procedures which applied, if any, to record the fact that a drug had been borrowed from another ward and brought back for example to Wards





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

DD 5

4A/4B?

A. To my knowledge there was no recording unless it was a narcotic.

Q. All right. Again, talking about non-controlled, non-narcotic drugs.

A. Yes.

Q. Would the head nurse or registered nurse from whom the drug was borrowed be required to make any recording of that or otherwise note it in the documents particular to her ward as best you understood the situation?

A. No.

Q. All right. To the best of your knowledge then was there on an ad hoc basis a relatively reciprocal arrangement between wards such that medications could be freely borrowed if required from what were considered to be non-controlled drugs?

A. Yes.

Q. Could we turn generally then to the situation of record keeping by nurses, Ms. Browne, and we have heard from a number of witnesses to date, from no witness representative of the nursing staff at the hospital but from a number of physicians as to the recording of notes by nurses for example in the medical charts of patients for whose care they were





DD 6

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

responsible or in whose care they participated.

We have seen, for example, in the medical records of a number of children whose deaths we are reviewing notes made by various nurses in what are described as the progress notes of those charts. On Wards 4A/B, to the best of your knowledge, where was the medical chart of any given patient kept on a continuing basis?

A. It was kept at the nurses' station.

Q. At the central nursing station?

A. Yes.

Q. All right. Did this apply, to the best of your knowledge, at night as well as during the day shift?

A. Yes.

Q. Was that practice uniform throughout the hospital or was that a matter particular to Wards 4A/4B?

A. I think at that time it was fairly standard.

Q. All right. When as a matter of general routine would a nurse make her note, if any, in the progress notes of a particular medical record?

A. She might make them when she





DD 7

1

2

took a break or she might wait and do her charting at  
the end of the shift.

3

4

Q. So, in some situations the  
charting could be done at the end of the shift before  
the nurse left the hospital?

5

6

A. Yes.

7

8

Q. All right. We have heard about  
the situation where nurses can be assigned to constant  
care duties, and if I understand that concept  
correctly, it means that one nurse, as you have told  
us earlier this morning, is assigned to one  
particular child and remains for the most part in  
that patient's room. Do I have that correct?

10

11

12

13

A. That is correct.

14

15

Q. Well, having regard to the fact  
that the medical record of the patient is kept at the  
central nursing station, how then would a constant  
care nurse do her charting with respect to that child  
if any difficulty arose?

16

17

18

19

A. She would either do it on paper  
at the bedside or she could take the chart there.

20

21

Q. All right.

22

A. It depended if family were there  
and how busy the room was.

23

24

25

Q. Assuming that she did not at the







DD 8

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

beginning of the shift take the medical record with her into the patient's room, would she make her notes and observations on any piece of paper that happened to be there or was there a formalized procedure in place on Wards 4A/4B?

A. We used a formalized form called a fluid record worksheet.

Q. We have previously marked in evidence, Mr. Commissioner, as Exhibit 154 a document entitled "Fluid Record Worksheet". Are these the forms that would be used by constant care nurses when making notes physically in the room of the patients for whom they were caring?

A. Yes.

Q. What would happen at the end of the shift, Ms. Browne, when the constant care nurse was due to leave the hospital, how would she communicate the information that she had recorded on one of these sheets to the medical record of the child?

A. She would take it to the nurses' station and transfer that information onto the patient's chart.

Q. Was it required of the constant care nurse that she transcribe any notes from the worksheets right into the medical record itself?





1

2

A. Yes, it would be.

3

Q. Were the worksheets kept

4

routinely in respect of any given patient?

5

A. They were kept for a few days

6

at the bedside and then were discarded. They weren't  
part of the permanent record.

7

Q. All right. With respect to the

8

matters which should be noted in the medical record

9

you told us earlier and explained for us what the

10

problem oriented medical record concept entails. Can

11

you help me as to what matters were required to be

12

noted in the progress notes by a nurse on Wards 4A/4B?

13

A. What was required on a routine

14

patient?

15

Q. Yes.

16

A. It would be vital signs, any

17

change in their vital signs, any change in behaviour.

18

Q. Anything else that you can think

19

of?

A. They would report if there was

20

any concerns around the family.

21

THE COMMISSIONER: I am sorry, I didn't  
hear that, what was that you said?

22

THE WITNESS: About family.

23

THE COMMISSIONER: Oh, yes.

24

25

DD 9





1

DD 10

2

3

THE WITNESS: And would record any  
procedures that had been done.

4

5

MS. CRONK: Q. What if medication  
had been administered to the patient involved, would  
they be recorded?

6

7

8

9

10

A. Medications would be signed off.  
Most of the children were on intake and output which  
meant that they kept careful record of what the child  
drank and ate and then what volume the child would  
have pee'd and any bowel movements.

11

12

13

Q. And all of that was required  
to be set forth in the progress notes by the  
responsible nurse prior to leaving at the end of her  
shift?

14

15

A. No, no.

16

Q. All right.

17

18

19

20

A. The latter item that I mentioned  
being the signing off of medication, there was a  
medication and treatment record where the nurse would  
sign by time and there was a fluid balance record  
which was a 24 hour record of the child's intake and  
output.

21

22

23

24

25

Q. All right.

A. And that is where those figures  
would go.







DD 11

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. I will come back to the medication treatment and record sheet in a moment.

Dealing generally with the types of entries that we have seen in the progress notes of some of these children, Ms. Browne, we have seen in a number of cases an entry made by a nurse indicating that a patient's condition was stable. In your experience and as a registered nurse and given your exposure to these wards, as a clinical nurse specialist, what meaning would you attribute to that description if you saw it in the progress notes with respect to any given child?

A. It would say to me that the child was not in any danger, that the child's condition was no worse than it had been.

Q. As you are undoubtedly aware, Ms. Browne, we have heard lengthy evidence from Dr. Richard Rowe in these proceedings and I would like to refer you for a moment to one specific portion of his evidence. This is found, Mr. Commissioner, at Volume 19, page 3435. I simply propose to read it to you, Ms. Browne.

A. Thank you.

Q. Dr. Rowe testified:





DD 12

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

"I think that babies can appear to be stable when they are not really stable and they can certainly deteriorate, some of them, there is absolutely no question about that, but it depends ... Not always, but it depends very frequently on observation that is rather specialized in order to determine whether those babies are as stable as you might think prior to the deterioration.

That is because not everything that is under external observation by, say, a nurse or parent, would necessarily be sufficient guide to indicate a deteriorating, an infant who is deteriorating who could appear stable on the outside."

"And that is a difficult problem because it obviously - it would demand for the thing to be satisfied in terms of detection of that decay would be somebody who would be knowledgeable like the physician, pediatrician or cardiologist in this particular area,





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

DD 13

"being able to make observations that are different from those that I have described by others."

As a general proposition, Ms. Browne, do you agree or disagree given your own experience with the comments made by Dr. Rowe?

A. In terms that a child can appear stable?

Q. Well, let's deal with it in two parts.

A. Okay.

Q. Do you agree, as Dr. Rowe suggested, that babies can appear to be stable when they are not really stable and that the critical point of determination is trying to assess what their condition was immediately before the onset of their deterioration?

A. Can you go the first part separate from the second part?

Q. All right. Dr. Rowe was suggesting that although babies can appear to be stable they in fact can be in a state of deterioration and not physically be really stable at all. As a general proposition, would you agree with that in your experience?

A. I would agree with that.





DD/BM/ak

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. As I understood Dr. Rowe's evidence he was suggesting further that in order to determine or to detect actual deterioration in a child's condition rather specialized forms of observation would be necessary and he suggested that it might well require observation from a knowledgeable physician, pediatrician or cardiologist as opposed to a nurse or a parent who is observing the child. As a general proposition, would you agree or disagree with that?

A. I would agree.

Q. All right. Recognizing the vast experienced which a seasoned cardiologist or physician brings to the matter, is it also possible in your view that an experienced and seasoned nurse, if I could put it that way, may in some cases be able to detect subtle changes in an infant's condition as they happen, having regard to the fact that she is intimately involved in the moment to moment care for that patient. Is that also possible?

A. It is possible; there is a yes and no to that in that having been with the child for a period of time often you do pick up very specific, and they may be minute changes. The other side of that coin is some time when you are







3DD2

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

with a child for a long period of time you may not pick up as readily as someone who, say, saw the child a half an hour ago and comes in and says they can see a big difference.

Q. All right. So, it can work both ways?

A. I think so.

Q. Ms. Browne, I would like to turn now to the issue of what the procedure is that applied on Wards 4A/4B when a particular physician made a specific order for a particular form of treatment or a particular medication for a patient. We have seen in various medical records a document entitled Doctor's Orders Sheets.

A. Yes.

Q. When a doctor ordered a particular medication on Wards 4A/4B, how would that ultimately come to be recorded in the medical record of the patient?

A. When he wrote an order in the chart he would what we call flag the patient's chart. There was a red section of the binder that came down, so, at a glance you saw there was a doctor's order that hadn't been recorded. It would then be the responsibility of the nurse in charge or the team





3DD3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

leader to look at that order. She would see if indeed there had been a pharmacy requisition made out if it was not a stock drug. She would then go to the medication and treatment sheet. She would write down the medication, the dose and the times. She would fill out a medication card with the child's name, the date, the medication, the dose, the route and the times. She would go to the child's nursing care plan, which was a plan of direction for the nurse caring for the child at the bedside. She would record the medication, again, the dose, the route and the times and she would then let the nurse caring for the child know what had been ordered. She would then sign off that that medication had been transcribed, that prescription.

Q. All right. Could I take that step by step?

A. Yes.

Q. The doctor, as I understand it, or the physician who orders the particular drug for the patient completes first a doctor's order form. Do I have that correctly?

A. That is correct.

Q. Is it then the responsibility of any nurse on Wards 4A/4B or a particular nurse





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

to transcribe that order onto the medication  
treatment sheet in the child's medical record?

A. It would be the responsibility  
of the charge nurse or the team leader.

Q. And would that apply to all  
patients under their care on their ward?

A. Yes.

Q. And all orders with respect to  
the patients on their ward?

A. Yes.

Q. All right. And then in that  
situation either the charge nurse or the responsible  
team leader would actually physically transcribe  
the doctor's order onto the medication treatment  
record?

A. That's right.

-----







E/DM/ak

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. And that is a document kept as a permanent record in the medical record of the child?

A. Yes.

Q. You referred as well to something called the Medication Card. Could you explain to me what those are, where they are kept and what the purpose is?

A. The medication card is a working reference I guess to that order. It is a small green card, about 1½ inches by 1½ inches with the child's name, again the medication, the dose, the route and the times on it. The nurse then will put the date and usually her initials on that card when she has taken the order off. That card is then kept in the medication room. There are slots for specific times, so that if a medication is due at 9 o'clock the nurse would go to the medication room, look at the cards in the 9 o'clock slot and that child's name and the medication should be there, and she would use that card then as her order for the medication that she would go ahead and pour.

Q. Whose responsibility was it to place both the medication card and the medication in the appropriate time slot?





EE2

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

A. It would be the team leader or the charge nurse's responsibility to put the card in the appropriate slot initially.

Q. I am sorry?

A. And then it would be up to the bedside nurse caring for that particular patient to see that that card returned to the appropriate spot for the next dose.

Q. I think perhaps I have misunderstood, because I thought you said that the medication card together with the medication would be in the appropriate time slot.

A. No.

Q. Just the medication card?

A. Just the medication card.

Q. And you have told us as well something about what you described as the Nursing Care Plan?

A. Yes.

Q. Is that something separate and distinct from the medication card that you have just described?

A. Yes.

Q. Can you tell us what that is please?





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. It is a heavy cardboard form used by nursing, it is the standard form, where we record specific information about the child and its treatment plan, and that's it, it is used as a very quick reference for the nurse and a guide to her nursing care.

Q. And where are they kept?

A. They are kept on the child's chart.

Q. Are they kept indefinitely?

A. No, they are not a part of the permanent record, they are taken off the chart at the time the child is discharged. Usually they are kept on the ward for a period of time after if it is a child who is likely to be admitted again, otherwise they would be destroyed.

Q. Do they serve really as a formal check list, if you will, for the involved nurses as to what treatment was to be applied or prescribed for the child?

A. A check list in what way?

Q. I am just trying to understand the concept, was it really just a summary form of document for the involved nurses to know what the intended care was for any particular patient?





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

EE4

A. Yes. It was done in pencil

so that things could be erased and new things added.

Q. Were the medication cards that

you placed in these time slots in the medication rooms

kept indefinitely?

A. No, when the medication was

discontinued the card was torn or cut up.

Q. I take it that in the case of

any medication which had been ordered by a physician

to be given to a child, there should at the time of

its administration have been an accompanying medication

card confirming the amount of the dose and the child

to whom the medication was to be given?

A. That is correct.

Q. As part of your responsibilities

on Wards 4A/4B, did you have occasion during the

nine months that we are concerned with to familiarize

yourself with the Ward 4A/4B policy book, did you

have occasion to ever look at that book and what was

contained in it?

A. The policy manual that we have

been talking about?

Q. I am sorry, I am suggesting

this is the second kind of document called the Ward

4A/4B policy book particular to those two wards. It







EE5

1

2

is my understanding it was kept on Ward 4A/4B. Did  
you ever have an opportunity to look through that  
book?

5

A. I am having trouble deciding  
what you are referring to.

7

Q. Perhaps if I could assist you.

8

THE COMMISSIONER: I wonder if this  
is a convenient time?

9

10

MS. CRONK: I'm sorry, sir, I lost  
track of the time. Thank you.

11

THE COMMISSIONER: We will take  
15 minutes.

12

13

---Short recess.

14

---Upon resuming.

15

THE COMMISSIONER: Yes, Ms. Cronk.

16

MS. CRONK: Thank you, sir.

17

Q. Ms. Browne, I am referring to  
you what I understand to be an extract from the  
Ward 4A/4B policy book entitled "Transcribing of  
Doctors' Orders - Guidelines". Can I ask you to  
look at these and tell us whether or not you have  
seen that before?

21

22

A. I have seen that before.

23

Q. To the best of your knowledge  
are these the guidelines that applied on Wards 4A/4B

24

25





EE6

1  
2 for the transcribing of Doctors' Orders during the  
3 period July 1980 to March 1981?

4 A. Yes.

5 MS. CRONK: Could that be the next  
6 exhibit, please, sir?

7 THE COMMISSIONER: Exhibit 293.

8 ---EXHIBIT NO. 293: Extract from Ward 4A/4B  
9 Policy Book entitled  
"Transcribing of Doctors'  
10 Orders - Guidelines".

11 MS. CRONK: I don't intend to go  
12 through this in detail but rather simply to have  
13 that before you.

14 Q. Ms. Browne, can I ask you to  
15 turn if you will please to Section 14.10 of the  
16 Nursing Manual, which is directed to the subject of  
17 PRN medications. Would you describe for us please  
what a PRN medication is?

18 A. It is a medication that is  
19 ordered or prescribed as needed by the patient.

20 Q. Can you help me further with  
21 that; would there be instances in which digoxin was  
considered to be a PRN medication?

22 A. No.

23 THE COMMISSIONER: PRN stands for  
24  
25





1

2

something, doesn't it?

3

THE WITNESS: It does and I can't

4

retrieve it.

5

MS. CRONK: I suspect it is Latin,

6

sir, and I can't help you at all with it.

7

THE COMMISSIONER: You suspect it is

8

Latin?

9

MS. CRONK: Yes, and I can't help

10

you with it at all.

11

THE COMMISSIONER: I don't think even

a Latin scholar could help very much with it.

12

MS. CRONK: I'm sorry, it is initials

13

for Latin as I understand it.

14

THE COMMISSIONER: Yes, that's right.

15

MS. CRONK: I should have said that,

16

sir.

17

Q. With respect to PRN medications,

18

Ms. Browne, because the term has arisen briefly before

19

in prior evidence, would these be medications which

20

were prescribed on a routine and continuing basis for

21

a patient, or would they be medications prescribed on

an emergency or unusual basis?

22

A. They were not a routine.

23

Q. When you say they would be

24

prescribed as required, could you elaborate on that

25

EE7







EE8 1  
2 for me please?

3 A. Well, usually the order was  
4 written, and the one that comes to my mind most  
5 clearly is in response to a patient's need for  
6 medication for pain. An order would be written for  
7 a certain medication and a certain dose. With the  
8 frequency with which that could be administered,  
9 if indeed the patient is complaining of pain.

10 Q. Now, the policy set out in  
11 Section 14.10, paragraphs 1 and 2, those that applied  
12 to the recording, or acknowledging in writing that  
13 a PRN medication had been ordered and administered  
14 to a particular patient.

15 A. Yes.

16 Q. And I take it that on the  
17 basis of the policy that is there set out, it is  
18 the responsibility of a - well, I should ask you,  
19 was it the responsibility of the charge nurse or  
20 the team leader to record if PRN medication had been  
21 prescribed and administered to a child, whose  
22 responsibility was it?

23 A. Again it would be the team  
24 leader's responsibility to acknowledge that order  
25 and put it on the medication and treatment sheet  
and make out a card. It will be the nurse who is





1

2

3

4

responsible for that patient's care who would administer the drug to them and then note the time and sign that medication was given.

5

6

7

Q. Would that be noted as well in the normal course in the progress notes, in the medical records of the child that that was given?

8

A. Yes.

9

10

11

12

13

14

15

Q. Could I ask you as well to look at Section 14.12 if you would, which is directed to medications at the bedside. As I read the provision it is an absolute prohibition for any medication being left on or taped to a bedside table. To the best of your knowledge was that the policy which in practice applied on Wards 4A/4B during the nine-month period we are concerned about?

16

A. Yes.

17

18

19

20

21

22

23

24

25

Q. I note with some curiosity that the policy is directed to bedside tables, Ms. Browne; and I tell you that we have one instance in which the evidence indicates that a particular medication was taped in, at the minimum, in a syringe form at the foot of the bed of a particular patient. In your experience was it usual or unusual for medications to be taped to any part of a patient's bed on Wards 4A/4B?





EE10

1

2

A. Highly unusual.

3

Q. Was there any policy in place

4

of which you are aware which was directed to the

5

issue generally of leaving medications in a patient's

6

room other than the policy that is set out in Section

7

14.12?

8

A. I don't know of any other policy.

9

Q. I would ask you to look if you

10

would as well at Section 14.18, which is directed

11

to medication errors, and it provides that a medication

12

error, including an omission in giving the drug, or

13

in charting the administration of the drug, must be

14

reported to the nurse in charge, and that a patient

15

incident report had to be completed and distributed

16

as directed. To the best of your knowledge was that

17

the policy which in practice applied on Wards 4A/4B

18

again during the nine-month period with which we are

19

A. Yes.

20

Q. If an error occurred on those

21

wards, it was required first to be reported to the

22

nurse in charge; and secondly, it was required that

23

A. That is right.

24

Q. And that assumes I take it we

25





EE11

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

can agree that if a medication error was detected,  
that is the person who had committed the error  
recognized it as an error?

A. That is right.

Q. If a medication error had  
occurred on Wards 4A/4B and an incident report had  
been filed, was that a matter which in the normal  
course would be brought to your attention given your  
duties in connection with Wards 4A/4B?

A. Not routinely.

Q. You have told us that you  
primarily worked the day shift, and I think you said  
that you started at 7:30 in the morning?

A. Yes.

Q. If it had been perceived by  
the senior nursing staff connected with Wards 4A/4B,  
or by the Hospital administration that either or both  
of those wards were experiencing an abnormally high  
incidence of medication errors, would that be a  
matter which you would in the normal course have  
expected to be drawn to your attention?

A. I might, not necessarily  
routinely.

Q. From and after July of 1980,  
Ms. Browne, was it ever suggested to you by anyone,







1

2

EE12

3

4

be it someone from the nursing staff or the medical staff of the Hospital, that such a problem existed on either of those two Wards 4A/4B?

5

A. Would you ask that again, please?

6

7

8

9

10

11

Q. I was talking about the possibility of an abnormally high incidence of medication errors. My question to you is from and after July of 1980 did anyone ever suggest to you, be it someone from the nursing staff or the medical staff of the Hospital that such a problem existed on either of those two wards?

12

A. No.

13

14

15

16

Q. In the course of your other duties and responsibilities, Ms. Browne, were you required to become familiar with, or did you become familiar with the various forms in which different drugs were available on Wards 4A/4B?

17

18

A. Would you ask that again, please, I am sorry.

19

20

21

Q. As part of your duties, did you become familiar with the various forms in which drugs were available on Wards 4A/4B?

22

23

24

25

A. I had knowledge of that before I went there, no, that was not a focus in my time anyway.





EE13

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. I take it then we would be best to ask from others what forms, for example, Lasix came in during this nine-month period on those wards?

A. Yes.

Q. Or for example, digoxin?

A. It still would be better to ask someone who was administering it regularly.

Q. You have told us earlier, Ms. Browne, what the policy was, in terms of administering medications as it related to registered nurses and registered nursing assistants, were there occasions to the best of your knowledge when parents of patients on Wards 4A/4B were permitted to administer medications to their children on those wards?

A. Under the direction of the registered nurse who had prepared the medication, yes.

Q. Were there any restrictions that applied to the administration of medications by parents?

A. It would just be oral medication that they would give, and again it would be because the child would take more readily from the parent





1

2

than from the nurse.

3

Q. And in that situation, when

4

you say that it would have to be done under the

5

supervision of a responsible nurse, responsible

6

registered nurse, does that necessarily mean that

7

the registered nurse would be in the room at the

8

time the medication was administered?

9

A. I can't say necessarily.

10

Q. Is it possible then that a

11

parent or parents of any particular patient could

12

have been permitted to administer an oral medication

13

to their child if he or she was a patient on the

14

ward when a registered nurse or a member of the nursing  
staff was not present?

15

A. I think that was possible

16

given the busyness of the ward, the nurse would make

17

a decision if there was something else she needed to  
do, that might be the case.

18

Q. Were there any procedures in

19

place of which you are aware, or any restrictions

20

which applied on those two wards which would inhibit

21

or prevent access to the medication cupboards by

22

other than nursing or medical staff?

23

A. Would you repeat the question.

24

Q. Were there any procedures or

25

EE14







EE15

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

restrictions in place of which you were aware on those two wards which would prevent or inhibit accessing the medication cupboards by persons other than medical staff or nursing staff?

A. There was no specific provision. The medication room always had the door closed so children did not wander in, and indeed it would be highly unusual to see parents in the medication room.

Q. Were the doors to those two rooms kept locked on a routine basis?

A. They were not locked, they were just closed.

Q. I take it from what you have said that if someone other than a member of the nursing staff or the medical staff were noticed in either of those two rooms that would be something about which a nurse who observed it would remark, would notice it, would that be fair?

A. She would remark and indeed if it was a parent they would be asked to leave.

THE COMMISSIONER: When you say that the doors were kept closed, did they close automatically or just that that was the general rule to have closed doors?

THE WITNESS: It was just a general





1

2

EE16

rule, they were quite a heavy door.

3

THE COMMISSIONER: That means that

4

they remained closed or they remained opened?

5

THE WITNESS: I don't know whether

6

they could automatically be pushed to stay open.

7

8

9

-----

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25





BN.jc  
FF

1

2

3

4

THE COMMISSIONER: But would they  
close on their own when you came out of the door,  
like a refrigerator?

5

THE WITNESS: It was not automatic, no.

6

7

8

9

MS. CRONK: Q. As part of your duties  
in the Cardiology Department, Ms. Browne, were you  
required on occasion to participate in resuscitation  
efforts or arrest procedures in the event of a  
calling of a Code 23 or a Code 25?

10

11

12

13

14

15

16

A. I never was involved in the  
actual resuscitation procedure itself. When a Code 23  
or 25 was called, I did immediately go to the area,  
would check to see if I could be of assistance to  
the nurses who were actually involved in the  
resuscitation, but generally responded to the needs  
of the children and families otherwise on the ward.

17

18

19

Q. I take it, then, if you did  
attend on a ward after a Code 23 or a Code 25 had  
been called, your attention primarily would be  
directed to the family of the patient concerned?

20

A. Yes.

21

22

23

24

25

Q. And of necessity, having regard  
to your normal working hours, if an arrest did occur,  
you would be there only if it occurred during the day;  
do I have that correctly?





FF.2

1

2

A. That is correct, yes.

3

4

5

6

Q. Are you familiar, Ms. Browne,  
with the general guidelines which applied and the  
procedures which applied for resuscitation procedures  
on Wards 4A/4B during that 9-month period of time?

7

A. Yes.

8

9

10

11

12

13

Q. I am showing to you, Ms. Browne,  
the document entitled "Emergency Resuscitation  
Procedure and System as Related to Nursing, The  
Hospital for Sick Children Nursing Procedures Manual"  
and on the front of that is a memorandum from  
Mr. Snedden of the Hospital to various persons  
outlined on the distribution list dated April 13, 1981.

14

15

16

17

18

Leaving aside for a moment the  
memorandum from Mr. Snedden, would you take a moment  
and look at the resuscitation procedures that are  
outlined and tell me if they are the procedures that  
applied on Wards 4A/4B to the best of your knowledge  
during the 9-month period of which we are concerned.

19

20

THE COMMISSIONER: It certainly has  
an authentic look.

21

MS. CRONK: I am sorry, sir?

22

THE COMMISSIONER: I say it has an  
authentic look.

23

24

25

MS. CRONK: Q. Do you recognize it as







FF.3

1

2

being the applicable guidelines?

3

A. Yes.

4

5

6

7

8

9

10

11

12

MS. KITELY: Mr. Commissioner, if my friend is referring to the document I think she is, and I am just about to get mine, it has attached to it at the very back, if you look at the last four sheets, three of them are charts and the fourth one refers to "Do Not Resuscitate Orders". This was the form in which the document I gather has now been made an exhibit and the form in which it was presented to the witness in the interview with Ms. Cronk on Monday.

13

14

15

16

17

The witness has done some inquiring since then about those pages, and I would ask Ms. Cronk to try to have the witness identify those, if possible. She has identified the memorandum, but there is some question whether those three pages belong where they now are.

18

19

20

21

22

23

24

25

MS. CRONK: I am grateful to my friend.

Q. Could I ask you, Ms. Browne, to look at the three charts which appear at the end of the document. I can tell you that the document in its entirety was provided to Commission Counsel in this form by the Hospital as representing the various procedures within protocol which applied to





FF.4

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

resuscitation efforts during the 9-month period, but I do note those three charts at the back. Do you know what they relate to?

A. No, I do not.

Q. Do you know who the author of the charts is?

A. No, and they look incomplete to me.

Q. If we take a look at the very last page of the exhibit, as Ms. Kitley properly points out, it is a document entitled "Procedure for Do Not Resuscitate Orders". It is dated March 1976 at the bottom. To the best of your knowledge, was this the procedure that applied on Wards 4A/4B for non-resuscitation order situations during the 9-month period of time that we are concerned with?

A. Yes.

MS. CRONK: It appears, sir, that a problem arises then only with respect to those three charts, and subject to your views, I would suggest that they remain as marked subject to later identification through various other nursing witnesses.

THE COMMISSIONER: Yes, all right. Thank you. That is Exhibit 294.

--- EXHIBIT NO. 294: Memorandum from J. Douglas Snedden, dated April 13th, 1981; with attachments.





FF.5

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MS. CRONK: Q. With respect to the memorandum briefly that appears at the front document, if you will, to the guidelines, Ms. Browne, as I understand it, this is a memorandum which was provided by Mr. Snedden to the Head Nurses, amongst others, on Wards 4A/4B outlining the protocol which was to apply with respect to the taking of a digoxin level in respect of a patient on Wards 4A/4B and as the memo is dated April 13, 1981, I take it that it applied from that day forward?

A. Yes.

Q. May we turn then for a moment to the emergency resuscitation procedures per se, and in the first two paragraphs on page 1 we see that the objective is stated to be:

"To provide basic life support to a patient who has suffered unexpected cardiopulmonary arrest."

And secondly:

"To provide and assist with equipment and drugs for use of the emergency resuscitation team in the performance of advanced life support."

I am particularly interested, Ms. Browne, in the various procedural steps which are outlined in the







FF.6

1

2

balance of the memorandum.

3

4

5

6

7

8

9

10

11

The first several pages of the guidelines are all dated September 1980, and amongst the steps to be taken, the first outlined is that the nurse at the bedside, on assessing that a patient has arrested, is to activate the emergency call system by calling out 25, and on hearing that, the unit clerk on the ward or the nurse nearest to the telephone was to dial the switchboard and indicate that a Code 25 had been called; do I have that correctly?

12

A. That is correct.

13

14

Q. Was that the procedure, as you understood it, at the outset of a Code 25?

15

16

17

18

19

A. Yes.

Q. Then if we turn to page 2, we see in Step No. 3 an indication of what the switchboard operator is to then do once he or she is informed of the calling of the Code 25, and in Step No. 4 this is noted:

20

21

22

23

24

25

"4. A second nurse will take the emergency tray and cart to the bedside and assist with basic life support."

Now, to the best of your knowledge, and this may not be something about which you can assist us, Ms. Browne,





FF.7

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

but to the best of your knowledge, if a Code 25 was preceded by a Code 23, would the emergency crash cart or resuscitation cart on Wards 4A/4B be taken into the patient's room at that time or would it remain outside the room until the calling of the Code 25?

A. It would depend the distress of the child, but if there was a very real question in their mind at that time that they placed the 23 that the child was going to arrest, the cart would be in the room.

Q. Was that a common event in your experience that it would be there prior to the calling of Code 25?

A. Yes, and if it was not there in the room, it would be outside the door.

Q. And if we look at Step No. 7, we see an indication that a registered nurse was to draw up and label certain drugs, and they are expressed to be sodium bicarbonate, calcium gluconate, epinephrine and others as necessary, and beside that, the indication that sodium bicarbonate and epinephrine came in pre-mixed syringes.

To the best of your knowledge during this 9-month period, was the sodium and the epinephrine medications which were found on the





FF.8

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

(2)

Wards 4A/4B crash carts found in a pre-prepared syringe form?

A. Yes.

Q. And do you know whether the calcium was in a pre-prepared form or not?

A. I do not think it was at that time.

Q. And if we look to Step 11 on the next page, there is an indication that an assisting registered nurse was to prepare the intra-venous cut-down tray, prime the administration set and begin recording proceedings, noting the time of arrest and all drug administrations.

Insofar as you are aware, Ms. Browne, was a particular system in place whereby a particular nurse was assigned the task of recording the events that took place during the Code 25 procedure?

A. It was not pre-determined. It would be determined on who was there assisting in the room, and along with the medical staff who were called to the arrest, the nursing supervisor would come. If at the time that she arrived there was not someone designated to record, she would designate one of the nursing staff to do that.

Q. Was there any particular rule







FF.9

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

in place as to which nurse at the scene of a Code 25 was to label and draw up the resuscitation drugs?

A. It would be whoever came in, and it usually was the third nurse because the first two were already involved in the resuscitation effort.

Q. Ms. Browne, did you have occasion, by virtue of your position, to become familiar with the contents of the resuscitation cart on Wards 4A/4B?

A. I was fairly knowledgeable of what was there. I was more aware of it when I worked as a staff nurse.

Could I clarify that priming the administration set was connecting the IV, setting it up.

Q. Thank you. Ms. Browne, I am showing to you a copy of a photograph that was marked, Mr. Commissioner, as Exhibit 29B at the preliminary hearing concerning Susan Nelles, and the photographer's description is that it is a photograph of the contents of the list of resuscitation tray and crash cart on Ward 4A at The Hospital for Sick Children. Unfortunately, the photograph of the list itself is somewhat difficult to read and we have had it retyped on a second page, Ms. Browne, but











FF.11

1

2

3

4

photograph of the contents  
of the list of resuscitation  
tray and crash cart on Ward  
4A at The Hospital for  
Sick Children.

5

6

7

8

MS. CRONK: Q. I recognize that the  
photograph itself is somewhat difficult to read,  
Ms. Browne, but do you recognize this document,  
as a copy of the list of the contents of the  
resuscitation cart on Ward 4A?

9

A. Yes.

10

11

12

Q. And am I correct in my reading  
of it, Ms. Browne, that the resuscitation cart did  
not appear to contain any digoxin?

13

A. That is correct.

14

15

Q. In your experience, would you  
expect to find digoxin on a crash cart on Wards 4A/4B?

16

A. I had thought so.

17

Q. I am sorry?

18

A. I had thought so.

19

Q. So are you somewhat surprised  
to not see it there?

20

A. Yes.

21

THE COMMISSIONER: I am sorry, you  
say there was the photograph, did you say?

22

23

24

25





FF:12

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MS. CRONK: The first part of the exhibit is in fact a photograph, sir, of a list.

THE COMMISSIONER: Oh, it is a photograph of the list, but there was not a photograph of the tray.

MS. CRONK: That is right. No, it is a photograph of the list, sir.

THE COMMISSIONER: I have been trying to see one of those trays ever since we started.

MS. CRONK: It is hard to read, but I do not think there is a tray on it though.

THE COMMISSIONER: No, all right.

MS. CRONK: Q. Ms. Browne, we have heard something in evidence, to turn to a totally unrelated matter, about a system of evaluation at The Hospital for Sick Children called, and I believe I have this right, the Selected Attribute Variable Evaluation; have I done that right?

A. Yes.

Q. Can you tell me, please, briefly, what that system entails, what is it?

A. I think you will have to direct that to one of the head nurses.

Q. Then I did not do it correctly at all, all right.







FF:13

1

2

3

4

A. No, you did do it correctly,  
but I do not feel I can answer that most appropriately  
for you.

5

6

Q. Can we go this far together.  
I take it you are familiar in general with the system?

7

8

9

10

A. Yes.

11

12

13

14

15

Q. And am I correct that the  
system is -- well, perhaps to assist you, would you  
look very briefly at Section 25.01 of the Manual.  
Do you have that, Ms. Browne?

16

17

18

19

20

21

22

23

24

25

A. Yes.

Q. Would I be misstating the  
situation if I suggested that the system known as  
the Save System was designed to measured the quality  
of care being received by any particular patient?

A. No, that would be correct.

26

27

28

29

30

31

32

33

34

35

Q. And it was designed specifically  
to assess the quality of nursing care that was being  
provided?

A. Yes.

Q. As well my next question is  
directed to Section 25.02, Ms. Browne, because we  
have heard something about the system known at the  
Hospital by the name of NARvel, nursing attention  
requirement level. Are you as well generally





FF:14

1

2

familiar with that system?

3

A. Yes.

4

Q. Are you in a position to  
explain briefly for us what that involves or is it  
best directed ---

5

6

THE COMMISSIONER: It seems to me  
we have had this before. Is this not in the Dubin  
Report?

7

8

MS. CRONK: In part it is, sir.

9

10

THE COMMISSIONER: Do we need to go  
over it again?

11

12

13

14

MS. CRONK: Just as long, sir, as  
we have an explanation from the nursing side, if you  
will, at the Hospital as to whether that played any  
role in the care that they perceived they were able  
to afford these children.

15

16

17

18

My present purpose only was to draw  
the fact to your attention that it is addressed in  
the Manual itself and basically what the system  
involved.

19

THE COMMISSIONER: Yes, all right.

20

21

22

23

24

25

MS. CRONK: Q. Would it be correct  
again, based on the policy statement in the Manual,  
Ms. Browne, to suggest that that system as distinct  
from the Save System involved an assessment of  
essentially the number of nurses required, given the





FF:15

1

2

patient ratio on any given ward at any given time?

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

A. It was done individually on each patient to determine how much nursing time they required, but in a collective sense it was used in terms of staffing of the ward, yes.

Q. Was it also a system in place that would assist in determining whether or not there was a shortage or over-supply of nurses at any given time, given the patient population on a ward?

A. It would.

Q. Would I be correct in concluding that any further questions on that matter should appropriately be addressed to someone more directly involved on the wards?

A. If you would, yes.

THE COMMISSIONER: If we need further questions.

MS. CRONK: If we need further questions, sir.

-





GG/DM/ko

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Q. One final general matter, Ms. Browne, and that relates to the introduction of the clinical pharmacist to Wards 4A and 4B. We have heard in evidence from others, although the date of introduction remains for us somewhat uncertain, that at some stage in 1980 a clinical pharmacist was assigned to Wards 4A/4B. I take it you would agree with that?

A. Yes.

Q. To the best of your recollection when did that assignment take effect?

A. I think it was September 1980, but I may be no more accurate than anyone else is accurate.

Q. You may not be able to assist me with this Ms. Browne. I am showing you a second abstract from the Ward 4A/4B policy book which speaks to the ward pharmacy service pilot study to be conducted on Wards 4A/4B, which appears to outline the objectives and the duties of the clinical pharmacist to be assigned to those wards. Have you seen this document before?

A. When you gave it to me on Monday I haven't seen it before that.

Q. Not before that?









1

GG 2

2

A. No.

3

4

MS. CRONK: Sir, could this be marked,  
I suggest it be marked subject to further identification.

5

6

Q. Are you sufficiently familiar  
with the role of the clinical - I am sorry.

7

THE COMMISSIONER: Exhibit 296.

8

--- EXHIBIT NO. 296: Abstract from the Ward 4A/4B  
Policy Book.

9

10

11

MS. CRONK: Q. Are you sufficiently  
familiar, Ms. Browne, with the role of the clinical  
pharmacist on Wards 4A/4B to describe for the  
Commissioner what her duties were?

12

13

A. I can describe them as I saw  
them.

14

15

16

17

18

19

20

21

22

23

24

25

Q. All right.

A. Which would not be in any way  
a complete view of what she did. My view of it was  
that she was a resource available on the ward to  
nursing and to medicine. That she did go through the  
charts daily to look at the doctor's order and to  
compare those with the medication and treatment  
record in the child's chart and to check the  
medication cards. She was available periodically  
through the day and if we needed information on  
medication she would get it for us.





GG 3

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. To the best of your knowledge did the clinical pharmacist work on the night shift on Wards 4A/4B?

A. No.

Q. Did she work on the weekends to the best of your knowledge?

A. No.

Q. If I have understood you correctly, part of her responsibilities as you understood them was to check the medication cards, that is the drug that had been ordered for any particular patient, do I have that correctly?

A. Yes.

Q. Was she as well, as far as you are aware, required to check the orders that the physicians had made and compare them with the entries that had been made on the medication card?

A. I would think so.

Q. Insofar as you are aware was the clinical pharmacist involved in the actual administration of medication to any patients on Wards 4A/4B?

A. No. I assume she did look after some of the ordering of medications if the stock supply was low.





1

GG 4

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

Q. Did the ordering of medications have to be conducted through the clinical pharmacist after she was introduced to the ward?

A. I can't tell you that.

Q. Do you know how long the clinical pharmacist was assigned to those wards?

A. It was a continuing position as far as I know.

THE COMMISSIONER: And still is?

THE WITNESS: Yes.

MS. CRONK: Q. I am sorry, I just want to make sure, sir, throughout the period September 1980 to the end of March 1981 the clinical pharmacist was assigned to those wards?

A. She was.

Q. We know Ms. Browne that the cardiology wards were moved from Ward 5A to Wards 4A/4B at the beginning of April 1980, as I mentioned earlier this morning. Were you involved in the staff planning made necessary by that move?

A. Not the staff planning, no.

Q. We have heard in evidence that the changeover towards 4A/4B resulted in an increase to the number of beds on the cardiology wards, is that correct?





1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

GG 5

Do you know, I am sorry, perhaps the easiest way to do it is to suggest what the prior evidence has been; that is the beds went from 38 on 5A to 42 on Wards 4A/B.

A. That is correct.

Q. Does that accord with your recollection?

A. Yes.

Q. Am I also correct in suggesting that after the relocation Ward 4A had 19 beds, 12 of which were specifically infant size beds?

A. Correct.

Q. And after the relocation Ward 4B and 23 beds, 6 of which were specifically infant size beds?

A. That is correct.

Q. Other than the increase in infant beds Ms. Browne, did the changeover have any further direct consequences or changes for the cardiology nursing staff of which you are aware?

A. Well the whole staff was then divided into two groups, if you will, because we went from one head nurse with one nursing group to two head nurses and two wards. So it meant that teams were relocated and different arrangements were made







1

GG 6

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

depending on whether it was A or B side, and the staffing needs varied for A or B because of the number of infants.

Q. Other than the addition of the second head nurse, were any new or further nursing personnel introduced to those wards at that time, or do you know?

A. I don't know.

Q. Other than the change then in the administrative nursing structure on the ward and the increase in number of beds per se, were there any other direct consequences in the nursing staff in the Cardiology Department of which you are aware?

A. What happened with that change was the nursing staff had been on a five week rotation, out of that five weeks they did two weeks of night duty. With the move to 4A/B and the increased need in caring for a larger number of infants, the nursing staff went to a four week rotation, they were on a 12 hour shift and it meant they did two weeks of nights and two weeks of days, so it was an increase in the number of nights.

Q. Two weeks of days consecutively and then two weeks of nights consecutively?

A. Yes.





1

G 7

2

Q. Did that apply to all teams on

3

Wards 4A/4B?

4

A. Yes.

5

Q. And to all team leaders on 4A/4B?

6

A. Yes.

7

Q. Did it directly affect the head  
nurses in terms of their day and night shift duties?

8

A. No.

9

Q. Did they continue to work days

10

only?

11

A. The head nurses continued to

12

work days.

13

Q. Do I have it correctly then that

14

in respect of any given team member she would be  
working both days and nights on a two week rotational  
basis?

16

A. That is correct.

17

Q. And the same would be true of

18

team leaders?

19

A. Yes.

20

MS. CRONK: Sir, I am about to move  
into a different area, would this be a good time?

21

THE COMMISSIONER: Yes, I guess we will

22

continue this on Tuesday.

23

MS. CRONK: Right, sir, Dr. Kauffman is

24

25





1

2

returning on Monday.

3

4

5

6

THE COMMISSIONER: I asked, I don't know if I got an answer whether there was any possibility of our starting at 9:30. Was there something Miss Kitley?

7

8

9

MS. KITLEY: I have two comments to make before you rise.

10

11

THE COMMISSIONER: I was going to say something about Monday.

12

13

MS. KITLEY: All right, I will be dealing with Tuesday.

14

15

16

THE COMMISSIONER: You are concerned about Tuesday. I take it that Dr. Kauffman, you are taking Dr. Kauffman?

17

18

MS. CRONK: I am, sir.

19

20

THE COMMISSIONER: Do you happen to know when he is arriving?

21

22

23

MS. CRONK: I think it will be a little tight sir to start at 9:30.

24

25

THE COMMISSIONER: All right, we won't try then. If I just can go back I can tell you --

MS. CRONK: Sir, could the witness perhaps be excused?

THE COMMISSIONER: Yes, thank you, until Tuesday at 10 o'clock then.

--- Witness withdraws







GG/DM/ak

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

THE COMMISSIONER: Miss Symes, if she is available has 15 minutes, it is going to be terribly tight because Dr. Kauffman will only be here for one day. Mr. Olah has half an hour. Miss Jackman is an hour. Mr. Labow has one half hour. Mr. Tobias has one half hour, and that takes us up to one o'clock. So that no one will be allowed to go over, if someone is under then we will be very appreciative, that's all.

Then in the afternoon, Mr. Shanahan is starting at 2:15, he will have 22½ minutes, I don't know how that came out. Mr. Hunt gets an hour and Miss Cronk will get ---

MS. CRONK: Three and a half minutes.

THE COMMISSIONER: Whatever you are allowed at the end.

THE COMMISSIONER: That is all then, I'm afraid I am going to have to have a stopwatch out and stop you, so you will have to act accordingly.

Yes, Mr. Shanahan?

MR. SHANAHAN: Mr. Commissioner, you did permit me the indulgence to be scheduled at 2:15, and certain things have occurred that I might not be here, but if I am not I have discussed it with Ms. Cronk, I will take my lumps if I am not here.





2GG2

1

2

I have not instructed her, I am still confident I  
will be here, if not move on.

3

4

THE COMMISSIONER: Yes, all right,

5

but be here at 2:15 because you will go on at that  
time.

6

7

Yes, Mr. Young?

8

MR. YOUNG: I wonder if I could get  
some indication from my friend Miss Cronk and perhaps  
Miss Kitley as well as to how long they expect to be  
with this witness, so we have some indication of  
whether or not we should be reached for cross-  
examination on Tuesday, or Wednesday. I have a  
member of my firm who will undoubtedly ask me that  
question when I return.

9

10

11

12

13

14

15

MS. CRONK: I would expect, sir,  
to be an hour and then be finished.

16

17

THE COMMISSIONER: And Miss Kitley,  
I take it this is your client?

18

MS. KITELY: That's correct.

19

THE COMMISSIONER: How long?

20

MS. KITELY: An hour to an hour and  
a half, sir.

21

22

THE COMMISSIONER: Anyone else?

23

Is Miss Kitley the only person expressing any owner-  
ship?

24

25





2GG3

1

2

MS. KITELY: That is correct.

3

THE COMMISSIONER: I thought

4

Mr. Scott for a while until this ---

5

MS. CRONK: He appears to have

6

retreated somewhat from that position, sir.

7

THE COMMISSIONER: All right. Then

8

we will go in the usual order and I suppose you have

9

no idea what that is going to be. Well, it looks

10

as though whatever happens nothing will happen before

11

Tuesday afternoon, that is all I can say.

12

Yes, Mr. Tobias?

13

MR. TOBIAS: It was so long ago that

14

Dr. Kauffman was here that I frankly have forgotten

who still has to cross-examine him.

15

THE COMMISSIONER: You do I think.

16

MR. TOBIAS: I know that I do.

17

THE COMMISSIONER: All those people

18

I mentioned still have to. I know Mr. Shinehoft got

in ahead because he was leaving the country.

19

MR. TOBIAS: I believe you start

20

with Miss Symes.

21

THE COMMISSIONER: We conclude

22

Miss Symes' examination and she is allowed 15 minutes.

23

All right. I must say if people are not here we

24

just take advantage of that and go ahead without them.

25





1

2

MS. KITELY: About Tuesday, sir.

3

4

THE COMMISSIONER: Oh yes, I am sorry,  
what about Tuesday?

5

6

7

MS. KITELY: First of all apropos  
to the discussion we had earlier about certain  
anticipated evidence on statements.

8

THE COMMISSIONER: Yes.

9

10

11

12

13

14

15

16

MS. KITELY: Might I point out the  
one that started this controversy, namely that of  
Carol Browne, it was after the preliminary and we  
had a great deal of discussion much earlier on about when  
the inquiry's meter is supposed to stop in terms  
of time. I would ask you to take that into considera-  
tion when you are looking at it, quite clearly it  
did not form part of the investigation leading up  
to the charges.

17

18

THE COMMISSIONER: Yes, yes. All  
right, thank you. That will make a difference I  
would think. Yes, anything else? Yes?

19

20

21

22

23

24

25

MS. KITELY: The second issue, sir,  
is I don't know whether you have taken a view of  
the Hospital or not, but I can tell you I took one  
with my client on Wednesday through the courtesy of  
Mr. Batty and it made a tremendous difference to me.  
I don't know whether you have had any trouble grasping







2GG5

1

2

what is going on in that ward.

3

4

5

6

THE COMMISSIONER: I have a diagram, you know, as part of this thing, but you are quite right it would certainly help if we took a view. Can you sort of arrange a time with the Hospital?

7

8

MS. THOMSON: We would be more than happy to arrange a time for you.

9

10

11

12

13

THE COMMISSIONER: When would we cause the least trouble and commotion?

MS. THOMSON: We may, through

negotiations with Commission Counsel, perhaps we can set up a time that would be convenient for all concerned.

14

15

16

17

18

19

20

21

22

23

MS. CRONK: I would be delighted to do that and then I will speak to Miss Thompson at the conclusion of today, sir. Unless there be any misunderstanding you will recall that Mr. Strathy suggested that matter many months ago, and the concern that I maybe expressed at the time was it may very well be not only an inconvenience but a great intrusion of the medical care on that ward if all counsel in this room as well as yourself attended. I think it would be most difficult and most unfair to the Hospital --

24

25

THE COMMISSIONER: Would you bear





1  
2 that in mind that we don't want to do anything that --

3 MS. THOMSON: Indeed, Mr. Commissioner,  
4 I appreciate Miss Cronk's concern in that direction.  
5 We have taken a number of counsel on views as they  
6 have requested. We would hold that would still be  
7 our position to organize it to be the least disruptive  
8 to the Hospital and the staff.

9 THE COMMISSIONER: Yes, all right.  
10 I suppose you have to tell somebody in authority  
11 who we are. I would just as soon it wasn't generally  
12 known. My idea is, perhaps I don't intend to actually  
13 get a long white beard or anything, but I just want  
to go in and see it and go out, that's all.

14 MS. THOMSON: Especially to you, sir,  
15 that invitation has always been outstanding.

16 THE COMMISSIONER: All right, thank  
17 you. Anything else? Yes, Mr. Brown?

18 MR. BROWN: Just in response to a  
19 comment by Miss Kitley as to the time that statement  
20 originated. It would be my submission under Rule 6(2)  
21 that these matters related to the conduct of  
nurses in respect of the deaths under review.

22 THE COMMISSIONER: Yes, there is  
23 no question about that.

24 MR. BROWN: The time of origin I  
25





1

2

would submit does not preclude disclosure to relevant  
counsel.

4

5

6

7

8

9

10

11

12

13

14

-----

15

16

17

18

19

20

21

22

23

24

25







HH  
BN/cr

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

MR. BROWN: It may not be relevant to the police investigation, which is Phase 2.

THE COMMISSIONER: But it may well be relevant to Phase 2 yes, but if it were going to have to come out in Phase 2 in any event, I would have been less concerned about the problem of whether it comes out in Phase 2.

Anything else?

All right, until Monday at 10 o'clock.

---Whereupon the hearing adjourned at 4:35 p.m.  
until Monday, December the 19th, 1983.

- - - -





